Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:38 A M 2008 Mary Louise Vaughan January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🕅 F 87 1920 401-24-3491 Kentucky August 1, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show # 1 XYes 2 □ No notified Director Montgomery Rockville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ns 23a or must be n 20851 United States 13206 Aleutian Avenue · death v Completed by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any linjury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Quinn Price Benjamin Harrison Vaughan ဂ 19a. Informant's Name/Relationship (Type. Print)
Sister-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Rollins Avenue, Rockville, Maryland 20852 Sara Jane Vaughan/ Law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 11, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Funeral Service Licensee M01305 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Trocramio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -01 moomE to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🗓 No 4 Pregnant at time of death Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 1 Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ∑ Yes 2 □ No After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Natural Fe// 600 M 1 ☐ Yes 2 ☐ No Dec 25 2007 al or Attendi s after death. 2 X Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, ptc. (Specify) 28f. Location (Street and Number City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

7

Registrar

31. Date filed (Month, Day, Year)

Jeffrey Paul Muench, M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

laughn, Mary

January 4, 2008

5530 Wisconsin Avenue, Suite 1208, Chevy Chase, MD 20815

08-00193 Sha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

ameka William	1-		nt of Health and Mental Hy te of Death	Reg. No. 2008 00502
Physicia		egistrar . Decedent's Name (First, Middle,Last)	11	2. Date of Death Month Day Year 1138 hrs
edical Examin	er		//iAms	January 7, 2006
-	4	a. Facility Name (if not institution, give street and number) 7704 Belair Road	4b. City, Town, or Location of Death Parkville	Baltimore County
		. Social Security Number 6. Sex 7. Age (In yrs. last birtho		
Funeral Director	4	212-11-2550 1 M 2 XF 26	Yrs. Months Days Hours Min	December 1/1981 Country M.D.
à	_		r Location	10d. Inside City Limits
d how a		$M \cdot D$ N/A B	BATTIMORE	1 Yes 2 No
arylar 8a-f s	Director	0e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
the Ma or 2		3619 Glenmore Ave	21206	pecify Yes or No- 14. Race - American Indian, Black,
death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.) White, etc.
or ite	밁	1 Yes 2 >NO	1 Yes 2 No specify:	Specify: Black
hours after "natural",	ğ	15 Decedest's Education (Specify only highest grade completed) 16a. D	Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry
72 hou	ete-	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	Teme, AGENCY
5-0036 led within 72 hours Hygiene. other than "natur	Completed by	12th grade lyp.	ClAim & Advust	e (First, Middle, Maiden Surhame)
filed v filed v Hygi d oth		17. Father's Name (First, Middle, Last)	10.Modres Han	ORAL ANDERSON
MD 21215-0036 2 should be filed within 72 hours after h and Mental Hygiene. 27 is marked other than "natural", c unatic event, the Medical Examiner.	To Be	DAVI A MAGNER 19a. Informant's Name/Relationship (Type, Print) 19b		Rural Route Number, City or Town, State, Zip Code)
ages I and 2 shount of Health and Natisem 17 is in other traumatic		IRMA O'NEAL &	2004 GREENGAGE	Date 20c. Location - City or Town, State
ore, MEss 1 and 2 slot Health ar If item 27		cremato	ory or other place)	
Pages nent of ant: I		4 Donation 5 Other Specify: OAKL	AWA CEMETERS JI	An 15,200 BATTIMORE, MD.
Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of acility	An 15,200 BATTIMORE, MD. Al Home 21213 Line ST. BATTIMOREMIN Approximate Interval
	_	23a. Part I. Enter the disease, or complications that caused the death. Do no	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
Physician Medical		failure. List only one cause on each line.		Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
))	١	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	nine	Cause. Enter Underlying Cause C.		
insit. Eddl	Examiner	events resulting in death) Last Due to (or as a consequence of):		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	ledical	UNPENDED AMENDED		
760, cate be physic he bur	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 1 Live birth	Ectopic pred	23d. Date of delivery mancy Month Day Year
687 certifi nding	ian	nast 12 months?	Fetal death 3 Ectopic pred Other (Specify)	manay
Box death he atte	Physician/IV	1 Yes 2 No 9 V Unknown g Unknown		23e. Did tobacco use contribute to the cause of death?
P.O. Box 6876 es that the death certificat gigned by the attending phoe detached for use as the		Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown
ords, P w requires t as been sign should be c	ed b			
cord aw req as bee 2 shou	plet			autopsy prior to completion of cause of death?
Division of Vital Records, ral or Attending Physician: The law requins and records. In Director: After this certificate has been seled in by the funeral director, page 2 should be	Completed by		26.Place of Death (Che	100 2 100 2
ital Recician: The scrifficate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/C	15.0	rsing Home 5 Residence 6 Other: Scene
n of Vi ding Phys 1. After thii funeral di	<u>٩</u>	1 V Yes 2 No	. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject shot self
OD C ending ath. or: Af he fun	tion	1 Natural 5 Pending FOUND: FOUND: 113	UND: 1 Yes 2 V No	
Division spital or Attent cours after death heral Director: filled in by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, to	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7704 Belair Road, Parkville, MD
Di spital nours a neral I filled	Certification:	4 Homicide determined (Specify) Vehicle on Roa		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		last tex up	O.C.M.E.	January 8, 2008
		30. Name and address of person who completed cruse of death (Item 23a)		NO CARRA
\		Tasha Greenberg MD. Assistant Medical Examiner		MD 21201
Regis	tate	. U = 1 1	K Lacet	
Kegi	ગાદ		PIONAL	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State		State of Mary		partment of F ertificate of			gierie Reg. No. 🤈 🏳	100	00503
			Registrar 1. Decedent's Name ((First, Middle, Las	t)				2. Date of De	ath) U O	3. Time of Death
	Physicia		DWONE	WEDIN	GTON				Jan Jan	Day 4	Year 2008	730 AM
	/Medic Examin		4a. Facility Name (If n			· · · · · · · · · · · · · · · · · · ·	4b. City, Town, o	r Location of Death		4c. Coun	ty of Death	
7	LAGITITI	3	1128 F	PROCTEV	L 5T		BALTI	more	MD 212	02		
	Funeral		5. Social Security Nun	mber 6. So	7. Age (/	n yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Yea <i>r)</i>	9. Birthp	place (State or Foreign ntry)
3	Director		219-84-	-5867	☑M 2□F	45 Yr	5.		APRILS	1962	BA	LTIMORE
- 1	pu ,		Usual Residence of D 10a. State 1	Decedent 10b. County	11	Oc. City, Town o	r Location				1	I0d. Inside City Limits
	aryla show d at	_		10b. County			TMORE					1 ⊈Yes 2 □ No
	he M 8a-f otifie	ecto	MI)	hau		DALI	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	with t	ā	10e. Street and Numb		J		212	60		11	SA	
	is 23	Funeral Director	11.28 H	ROCIER	12. Was Decedent Eve	er in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No		ace - Americ	
	item item	5	1 Never Married	d 2□ Married	Armed Forces?				o Rican, etc.)		lack, White,	
36	irs af	by	3 ☐ Widowed 4		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec	city: BLI	9CK
21215-0036	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	bed	1	15. Decedent's Ed	lucation	16a. D	ecedent's Usual Occup Give kind of work done	pation	kina	16b. Kind of	Business/In	dustry
75	hin 7; an "n Medi	ble	Elementary/Second	dary (0-12)	College (1-4or 5+)		fe. DO NOT use retire	ia)		1		
21	led with	Completed	10 9RM	Z	NA		CITYOF			JA		ION
	e filed al Hygi I other vent, t	Be	17. Father's Name (F					18. Mother's Nam			ame)	
<u>Ja</u>	ould be Mental arked o atic eve	흔		WEDIN				MAXI			21.1. 7	0-4-)
Maryland	2 sho and is ma		19a. Informant's Nan	ne/Relationship (Type. Print)		Mailing Address (Street					
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Ithealth and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		MAXINE	FIELDS	WED INGT	20h Plans of F	006 E F	EDERAL	3T	20c Location	n = City or T	nn State
altimore	<u>0</u> 0 = 5	Ш	Zod: Monios of Ziopi		Removal from State	cemeterv.	crematory or other pia	ice) ;				
Ē	Pa men ant:			5 ☐ Other (Specif		MT	210N CEM 22. Name and Addr	ZTANY 1-	11-08	LAN	CE 100	UN MO
Bait	permit. Departr Importa any Inj		21. Signature of Fun				22. Name and Addr	ess of Facility	Betts	F Hane		
ш	205 # 9			CA BE							mu	Approximate
			shock, or heart	t failure. List only	plications that caused the one cause on each line.				or respiratory	arrest,		Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition resulting in death)	inal			LAR CA	VCER				
	/Medical Examiner		resulting in doctary		Due to (or as a	consequence of):					
k	LXUIIIII	_	Sequentially list condification in the sequential sequentially list conditions are sequentially list conditions.	ditions,	b Due to (or as a	consequence of	·				-	
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987	ficate phys	edical			G							
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ă	death atte	cial	in the past 12 r	months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnan 5 ☐ Other (specify)				Month	Day Year
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	law requires that the de as been signed by the a 2 should be detached i	by P	Part II. Other signifi	cant conditions	contributing to death but	not resulting in	the underlying cause g	iven in Part I.			•	the cause of death?
Records,	quire en sig uld b	pe pe							1	Yes 2 N	o 3∐ Pro	obably 4 Unknown
000	aw requir s been si 2 should	olet	i						24a. Wa	onsv I	tb. Were au	topsy findings available completion of cause of
Ä	0 5 0	Completed							per 1∐ Yes	formed? 2 No	death?	2 □ No
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~	ys dir	To E	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 Inpatien		Datient 3 DOA		dome 5 12 Re			oify)
n or	ding Ph n. After th funeral	Ë	27. Manner of Death	n 5 ☐ Pending	28a. Date of Injury (Month, Day		jury W		28d. Describe	e how injury oc	curred	
Sio	Attending r death. ector: After by the fune	äţi	2 ☐ Accident	investigatio				☐Yes 2☐No	00/ 1	(Change and Mr	umbar ar Ru	ıral Route Number,
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		y - At home, fan <i>(Specify)</i>	n, street, factory, offic	9	City or T	own, State)	umber or Au	rar House Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	3		100000	hysician: To the best of	my knowledge	death conserved at the	time date and place	e and due to th	ne cause(s) and	manner as	stated.
	Hospitai 24 hours a Funeral I tely filled	ica	(Check only	2 ☐ Medical Exa	miner: On the basis of	examination and	or investigation, in my	y opinion, death occ	urred at the tim	e, date and pla	ice, and due	to the cause(s)
	To the I within 2 To the I complet	Medical	one) 29b. Signature and	title of Attifier	and manner stat	ed.	29c. Lice	nse number		29d. Date si	gned (Monti	h, Day, Year)
	N N N			and one	MD			016619		Jane	w il	2008
					completed cause of de	ath (Item 33a) /	[vne Print)			produce	1	,
	4			ess of person who	OF S GALO	FRAN	KLIN SOL	DIGGIG WARE DR	BAI	TIMORE,	MI	1236
	1	tate	31. Date filed (Moni		32 Registra	FRAN Signature	1					
	Regist			081 1 1 20	ing A	1. 1	10000					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10:55 A M **Physician** THERESA UVETTE 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number Days **Funeral** 1 M 2 KF Months 213-66-9555 50 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Pres 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 21239 U.S. A 5402 Woodmont Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) eacher Education permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien important: If item 27 is marked other the any Injury or other treasment. **LOYIS** 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Josephine Poindexter George E. West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1539 Winston Ave Baltimore MD 21239

Date 200: Location - City or Town, State Josephine West/Mother 20a. Method of Disposition 1 ☐ Bunal 2 Defemation 3 ☐ Removal from State Greenmount Crematory 1/8/2008 Baltimore Mi 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 5151 Baltimore National Dike Baltimore MI) 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardio julmona Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 105513W Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Upper Chilesterdemic and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate has 1□ Yes the Hospitai or Attending Physician: director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA 1 🗌 Inpatient 1 🗌 Yes Certification: To this 28c. Injury at Work? 27. Mannel of Death 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury After 1 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 01-03-2008

State Registrar 31. Date filed (Month, Day, Year) JAN 1

J. HIRPARA

Bright Aild road pagnerille, mo 32. Registrar's Signature

30. Name and audioss of person who completed cause of death (Item 23a) (Type, Print)

08-00065
Bernard Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

sernard Wilson		epartment of Health and Mental Hy Certificate of Death	reg. No. 2008 0050
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day January 3, 2008 3. Time of Death 0815 hrs
٠ - ا	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral		yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	219-40-9447 1XM 2 F	65 Yrs. Months Days Hours Min.	Dec. 24, 1942 Country) MD
' any		City, Town or Location Baltimore	10d. Inside City Limits
ryland a-f show t once.	MD 10e. Street and Number	10f. Zip Code	1 X Yes 2 No
the Ma	1501 E. 28th Street	21228	USA
ter death with the Maryland ", or items 23a or 28a-f sh r must be notified at one r Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 X Yes 2	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
s after de real", or niner m	J Widowed 4 Divorced in res, Give real or Dates:	1 Yes 2 X No specify:	African American Specify: vork done 16b. Kind of Business/Industry
5-0036 ed within 72 hours lygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	
-003(d within rgiene.	12 17. Father's Name (First, Middle, Last) unk	laborer 18. Mother's Name	(First, Middle, Maiden Surname)
1215 d be file lental Hy arked o arked o		40b Mallion Address (Observed Number of	Rural Route Number, City or Town, State, Zip Code)
MD 21 12 should th and Me 27 is ma umatic er	Loleta Ray / Niece	4407 Cedar Garden ; Balti	more, Maryland 21229
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Purial 2 as Cromotion 2 Pomoval from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 01/2:	Date 20c. Location - City or Town, State 2/2008 Owings Mills, MD
Baltim permit. Pag Department Important: injury or of	4 Donation 5 Other Specify: 21. Signature of Furgeral Service Licensee		ylie Funeral Home, P.A.
	23a. Park Enter the disease, or complications that caused the c	638 N. Gilmor Stree	et: Baltimore, MD 21217
Physician /Medical :xaminer	failure. List only one cause on each line.	omplicating acute alcohol intox	Between Onset and
Xammer	or condition resulting in death) Due to (or as a consequent		
iner	Sequentially list conditions, If any, I acting to immediate cause. Enter Underlying Cause (Disease or injury that initiated	nce of):	
red misit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) d.	nce of);	
ox 68760, ant certificate be executed attending physician and or use as the burial - transit	X UNPENDED X AMENDED #1,23a,27,28	a-f.perME.g875, 1/29/08 TT	
18760 rtificate I ing phys as the by	IF FEMALE: 23c. If yes, outcome of 1 Live birth	f pregnancy 2 Fetal death 3 Ectopic pregn	23d. Date of delivery ancy Month Day Year
D. Box 6 t the death ce by the attend ached for use Physicia	1 Yes 2 No 9 Unknown 4 Pregnant at time	of death 5 Other (Specify)	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The taw requires that the death certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Existence.		not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
rds, Frequires been signould be			24a. Was an autopsy findings available prior to completion of cause of
of Vital Records, Ing Physician: The law requires After this certificate has been sig- uneral director, page 2 should be in: To Be Completed			performed? death? 1 Ves 2 No 1 Ves 2 No
fital Fiscian: sician: is certifi lirector, Be C	25. Was case referred to medical examiner?	26 Place of Death (Check 2 ER/Outpatient 3 DOA Other Nursi	only one) ng Home 5 Residence 6 Other:
of Vi	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division o Division o Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	Pending Accident Investigation Suicide Suicide Suicide Suicide Suicide Pending Investigation 28e. Place of Injury 28e. Place of Injury	8 Fnd 3:50 am 1 Yes 2 X No - At home, farm, street, factory, office building, etc.	subject exposed to cold environment 28f. Location (Street and Number or Rural Route Number, City
Div Spital o hours aff meral D y filled i	Suicide 6 Could not be determined (Specify) road		28f. Location (Street and Number or Rural Route Number, City N. Charles St. & E. Mount Royal Ave.
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should Medical Certification: To Be Complete.	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	owledge, death occurred at the time, date and place, an- tion and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
F 3 F 8	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 4, 2008
	30. Name and address of person who completed cause of death		
1	Ana Rubio MD. Assistant Medical Examine 31. Date filed (March, Day, Year)? Ω(1)Ω \$32. Registrar's S		1
State Registra	TAN P. I. ZUUO J. S.	The state of the s	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WASHINGTON Long 7:05AM /Medical 4a. Facility Nama (If got institution, give street and number) Baltimore 4b. City, Town, or Location of Death **Examiner** ALTIMOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 218-26-1161 83 12-14-1924 Arkansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MYes 2 No Director MD Baltimore N/A 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4202 Reisterstown 21215 Funeral Road USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 3rd grade <u>Steel Worker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Leona Ballard Johnnie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Austin - Niece 4202 Reisterstown Road Balto, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 1-16-2008 Owings Mills, MD 21. Signature of Juneral Service Licensee 22. Name end Address of Facility March F/H East 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4□Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 ☐ Yes 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) VI MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For	State of Maryland / Depa		lental Hygien	2000	00507
			State Registrar	Cer	tificate of Death	Reg. N	.2008	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)	D 1 1 1 C 1			year	1645 PM
	/Medic	al	EMMA	BAILEY	4b. City, Town, or Location of Death		lc. County of Death	1643 F
	Examin	er	4a. Facility Name (If not institution, give s	HOSPITAL	RANDALL STO		BALTIMO	RE
			5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs.	0.5	- 5:0	ace (State or Foreign
	Funeral Director			M 2/21 F / Yrs.	Months Days Hours Min.	(Month, Day, Yea	946 Sout	H CAROLINA
	7		Usual Residence of Decedent			SUNC DU		
	ylan how at	.	10a. State 10b. County	10c. City, Town or Loc	cation		10	d. Inside City Limits 1 1 Yes 2 No
	a-f s	cto	MARYLAND N/	A	BALTIMORE			
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Count	ry?
	23a ust b		3615 HOWAR	D PARK AVENUE	2120	7	USA	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther, the Medical Examiner must be notified at	Funeral	11. Marital Otatos		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: 13	ANV
5-0036	tural tural	D D	15. Decedent's Educ		dent's Usual Occupation	16b.	Kind of Business/Indi	ustry
15	n 72 "na" edic	ete	(Specify only highest grade	completed) (Give	kind of work done during most of work DO NOT use retired)			,
2121	withi iene. thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	USE WIFE		OWN HO	ME
	Hyg Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
<u>la</u> n	Mental arked o	To B	ROBERT	PEEL	E HATT	TE LE	E WHIT	FIELD
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	-	19a. Informant's Name/Relationship (Typ	pe. Print) 19b. Mailir	ng Address (Street and Number or Rur	al Route Number, City	y or Town, State, Zip	Code)
	and 2 salth a n 27 is		LATONVA DICKER	SON (DAUGHTER) 361	15 HOWARD PAR	KAVE, B	ALTO, MD	21207
ore	of He of Herr		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	20b. Place of Dispo cemetery, cren	osition (Name of matory or other place)	Date 20c.	Location - City or Tov	wn, State
Ĕ	Pages nent of I int: If Ite		4 ☐ Donation 5 ☐ Other (Specify)		EM PARK 01-1	4-08 W	DODLAWN	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show minoriant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	e 22	2. Name and Address of Facility	ROWNJR	. F-UNERA	2 HOME
<u>m</u>	8 2 E 8 8		facqueline	& pane	2148 N. FULTO	NAVE, BI	9LTO. MO	21217
			23a Part1. Ent of he disease, or compli shock, or of art failure. List only or	cations that chuse the death. Do not ent ne cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
·	Physician		Immediate Cause (Final diséase or condition	sensi			1	Offset and Death
	/Medical		resulting in death)	Due to (or as a c sequence of):				
ы	Examiner		Sequentially list conditions.)				
7	sit set	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events	Due to (or as a consequence of):				
V	ecute and -tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
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	physi the	dical						
9 X	w requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/Me	IF FEMALE:	3c. If yes, outcome pf pregnancy			23d. Date of delive	erv
Вох	leath atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)			Day Year
P.O.	the d y the iched	ysi	1 ☐ Yes 2 X No 9 ☐ Unknown	9□Unknown				
	s that ned b deta	Y P	Part II. Other significant conditions con	ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobaco	co use contribute to the	e cause of death?
rds	quires n sign	d b	unal face	ure		1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Records,	× q ts	i de	pour les différe	whose adenocarcinon	- 9 poncoco	24a. Was an	24b. Were auto	psy findings available npletion of cause of
R	The law ite has b	E E	* 0 00		0	autopsy performed 1 Yes 2 ☑	l? death?	-
Vital	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical		26. Place of Dea	th (Check only one)	100	
>	Physician: The la r this certificate has ral director, page 2	TO B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence	e 6 Other (Specify	y)
0	ng Ph ter th neral	٦	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred	
Ö	Attending r death. ector: After y the funer	atio	2 ☐ Accident investigation	DATE OF THE PARTY	M 1 ☐ Yes 2 ☐ No			
Division or	ir Att	ţįį.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, S.	t and Number or Rura tate)	I Route Number,
	ital carries af	Ö		1				
	Hosp 24 hou Fune Tely fi	ical	(Check only 2 Medical Exami	sician: To the best of my knowledge, deat iner: On the basis of examination and/or in	tn occurred at the time, date and place nvestigation, in my opinion, death occu	rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month,	Day, Year)
	7. ¥ 7. 8	_	255. Digitatal 5 and 100 of certifier				1-	2
	n		20 Nomen and and and putch	- MS	D005973	6	January 9	2008
	' }			ompleted cause of death (Item 23a) (Type,	, Printi) D. NORTHWEST	HOSPITAL	5401 040	LOURT ROAD
48	St	ate	31. Date filed (Month, Day, Year)	32. Hagistrar's Signature	Lash !	III AZ	3701 000	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Sharon Ann Crist 01-08-2008 1:03 A 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Belcamp 1219 Caldwell Ct South | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 11-09-1962 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1 ☐ M 2 🂢 F Maryland 212-76-7460 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Belcamp 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1219 Caldwell Ct South 21017 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Penn Pontiac Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doris Keenan Edward Holl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Caldwell Ct South Belcamp, MD 21017 Wayne Crist (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 01-11-2008 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final el002 la disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural

1 Yes 2 No

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and clace and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Ave

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Houre de Grace, MO

29d. Date signed (Month, Day, Year)

/Medical Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the e s certificate has t lirector, page 2 s or Attending Physician: director, this s efter death. il Director: After this id in by the funeral d

To the Hospital within 24 hours a To the Funeral completely filled

Physician

/Medical

Examiner

Funeral

Director

r then "natural, or iteme 23a or 28e-f ehow the Medical Examinar must be notified at

Directo

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Certification:

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

with the Maryland

death v

filed within 72 hours after

.. Peges 1 and 2 should be filed vitment of Health and Mental Hygie tant: if Item 27 is marked other fully or other traumatic event, it

permit. Pege Department of important: if any injury or once.

Physician

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Promila

6 ☐ Could not be

700 S. Union 172 32. Ragistrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4c. County of Death FRANCIS LAIR MANUARI 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 Ϊ F Months Days Hours 1071671914 NY 554-42-6922 93 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □ Yes 2 No OWINGS MILLS MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 21117 USA 3420 ASSOCIATED WAY, #101 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: WHITE 1 □ Yes 2 No Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ALLWEISS ESTHER** GREENHUT **ISRAEL** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26276 CAVE NECK ROAD, MILTON, DE BONNE' MORRISON / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition ARETNOTON-CHIZOR 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/11/2008 BALTIMORE, MD INC. AMUNO_CONG. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) chonaly Due to (or as a consequence of) Se_uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last URIMAR Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 25 No 24a. Was an autopsy performe 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 📆 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Drath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ↑ Natural 5 Pending investigation

Physician /Medical Examiner Examiner

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, traumatic event event

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed burial-tran and the as use for ed by the a page 2 certificate Hospital or Attending Physician:

Physician/Medical

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Completed

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Medical Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

6 ☐ Could not be

determined

MORTH WEST 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

and manner stated.

m.D

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number DHIHIO

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month Pay, Year) 108. Jahrara

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINGER P MENTR

Hospian CENTER RAMORUS TOWN

32 Registrar's Signature South

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00154 State of Maryland / Department of Health and Mental Hygiene George Dietz Certificate of Death 1- For State Rea. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Month Day January 6, 2008 0506 hrs DIETZ IV GEORGE HENRY **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil Union Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Foreign MARYLAND Months Hours Days Director 213-94-8134 12/1/1966 41 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No ELKTON 28a-f show CECIL MD or items 23a or 28a-f shov must be notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21920 U.S.A. 129 GOOSE NECK COURT 14. Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 Never Married 2 Married 2 X No Yes WHITE Specify: Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
injury or other transmatic event, the Medical Examiner. If Yes. Give Year Widowed 4 X Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) HOUSING PAINTER 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WARNS JOANN DIETZ **GEORGE** DIETZ III Η. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RD APT ESSEX, MD 21221 STRAWFLOWER D JOANN DIETZ MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/11/08 BALTIMORE, MD METRO CREMATORY 4 Donation 5 Other Specify 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVE BALTIMORE, 21237 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Acute myocarditis with early acute pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed and Physician/Medical physician a X UNPENDED X AMENDED 12 AMENDED 13 AMENDED 14 AMENDED 14 AMENDED 15 AMENDED 15 AMENDED 15 AMENDED 16 AMENDED 1 Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Year Day 3 Ectopic pregnancy Fetal death 2 past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown \$ ۵. Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✔ Yes 2 ✓ Yes No page After this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Other: 2 FR/Outpatient 3 DOA Inpatient 1 V Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey, Year) Manner of Death Yes 2 No X Natural Pending filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier January 7, 2008 O.C.M.E. MID

Registrar

32. Redistrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

4 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26, perVerbal, g875, 1/14/08 Centrificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 0 08 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2614 Greenmount Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 √F 88 200-18-8630 Yrs Director Jan. 6, 1920 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Director MD Baltimore 1√ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2614 Greenmount Avenue 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ☐ Yes 2 ☑ No Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 African American 1 ☐ Yes 2√ENo Specify þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working unk life. DO NOT use retired) unk r than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H cant: If item 27 is marked oth unk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizzie Linton / Guardian 10 N. Calvert Street; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Zion Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department o Important: If i any Injury or once. = 5 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/15/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home. P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1 femilier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 20 YOAKS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and sthe burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending I IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b 24a. Was an autopsy perform the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 27 Other: 4 Nursing Home 5 TResidence 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 atural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune Medical (Check only one) 29b. Signature and title of certifier 2 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, P 1000 CATHED RALST SHELDON

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09698 State of Maryland / Department of Health and Mental Hygiene Mykenzie Friedel Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 5, 2008 1043 hrs Mykenzie Medical Examiner Lynn Friedel c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Baltimore City University Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YY If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Foreign **Funeral** Hours Months Country) Maryland 213 79 6883 June 5 2007 Director 1 M 2 X F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Baltimore County Maryland Baltimore 28a-f show marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21237 USA 5906 Hamilton Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes White than "natural", or Yes 2 X No specify: Specify: Yes, Give Yea 3 Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit, Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r injury or other traumatic event, the Medical E. Not Applicable Not Applicable MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephanie Lynn Connolly Carl Conrad Friedel Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5906 Hamilton Avenue Baltimore, Maryland 21237 Stephanie Lynn Connolly (Mother) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Parkwood Cemetery January Donation 5 Other Specify: 22. Name and Address of Eacility
Lassahn Funeral Home Inc signature of Funeral Se vi e Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death Medical a.Undetermined Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/4/08 amh X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? After this certificate has 1 🗸 Yes 2 No ✓ Yes 2 No te Hospital or Attending Physician: The n 24 hours after death.

The Funeral Director: After this certifical letely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be Other, examiner? DOA Nursing Home 5 Residence 6 Hospital: 1 / Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27, Manner of Death Certification: 1 Yes 2 X No 1 Natural Pending Fnd 12/3/07 ınk 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be or Town, State) 3 Suicide determined (Specify) unk 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 2. To the F and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

ORIGINAL

Min

Assistant Medical Examiner

32 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 6, 2008

OCME

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

my M Gabbert	State of I	Maryland / Departmen <i>Certificate</i>	t of Health and Mental H e <i>of Death</i>	ygiene Reg. No. (2008 0051
Physician ledical Examine	Decedent's Name (First, Middle,Last)	GABBERT		2. Date of Death Month Day January 12, 2008	3. Time of Death Year 1843 hrs
	4a. Facility Name (if not institution, give stre		4b. City, Town, or Location of Death	4c. Cou	nty of Death
Funeral	Franklin Square Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs		nore County YYY) 9. Birthplace (State or
Director	220 86 7793 1_M		Yrs. Months Days Hours Min		Foreign Country) MARY AND
o min	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
Varyland 28a-f show any d at once.	MD BALTIMO	RE MIDDLE	RIVER		1 Yes 2 X No
tith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number		10f. Zip Code		f What Country?
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lib and Mental Hygiene, 177 is marked other than "natural", or items 23a or 28a-f shumanite event, the Medical Examiner must be notified at once TO Bo Compileted by Emineral Director			21220 B. Was Decedent of Hispanic Origin? (S)	US.	A Race - American Indian, Black,
r death v	1 Never Married 2 Married	Armed Forces? Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto		Vhite, etc.
s after ral", o	3 Widowed 4 Divorced if Ye	s, Give Year	Yes 2 X No specify:	Spec	
72 hour "natu	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	college (1-4 or 5+)	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use ret		of Business/Industry
within 72 hour giene. The than "nate Medical Exar	12	0 DIS	SABLED		n/a
21215-0036 July be filed within 72 Mantal Hygiene, marked other than 7 e event, the Medical	in in a trief s Name (r inst, Middle, Last)	* DD		e (First, Middle, Maiden Surn	
2121; buld be fil I Mental F i marked ic event, I		ABBERT Print) 19b. M	lailing Address (Street and Number or	L. TAYLO	
	STEPHEN R. GABBE		711 HURLOCK RD	BALTIMORE,	MD 21220
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr	20a. Method of Disposition 1 Burial 2 X Cremation 3 R	emoval from State crematory	isposition (Name of cemetery, or other place)		ion - City or Town, State
Itim ii. Pag uriment ortant:	4 Donation 5 Other Specify: 21. Signature Hint al Service Licensee				TIMORE, MD
Department of the partment of	(-8/		22. Name and Address of Facility CV A		
Physician /Medical	23a. Part 1. Enter the disease, or complication failure. List only one cause on each line				Approximate Interval Between Onset and
aminer	444	ortriptyline, Citalor o (or as a consequence of):	ram and oxycodone into	xication	Death
	Sequentially list conditions, b				
		o (or as a consequence of):			
uted nd ransit		o (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit policial Contification. To Re Commidsted by Dhysician/Medical Expedical Contification and	X UNPENDED	Sa,PII,27,28a-f, per	ME.g877 3/6/08 TT		
Box 68760, e death certificate be the attending physic of for use as the bur bure ician/Moor	IF FEMALE: 23 23b. Was decedent pregnant in the 1	c. If yes, outcome of pregnancy Live birth 2	Fetal death 3 Ectopic pregn		te of delivery th Day Year
Box 6876 The death certificate the attending physical properties as the long physical physical properties as the long physical ph	past 12 months? 1 Yes 2 No 9 V Unknown a	Pregnant at time of death 5	Other (Specify)		,
that the derected for detached for the street of the stree	Part II. Other significant conditions con	Unknown ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use o	contribute to the cause of death?
ires that the signed by be detach	Hypertensive ath	erosclerotic cardiov		1 Yes 2 No	3 Probably 4 Vunknown
Division of Vital Records, tat or Attending Physician: The law require after death. In Director: After this certificate has been six led in by the funeral director, page 2 should be artification. To Re Commisted	hepatosteatosis, lung	disease		autopsy	4b. Were autopsy findings available prior to completion of cause of
Recc The lar ficate ha				performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No
ital Recitions: The sector, page		al:	26.Place of Death (Check atient 3 DOA Other Nursi		
1 of Vital Recting Physician: The After this certificate funeral director, page	1 Yes 2 No	Impatient 2 Erocape	atient 3 DOA Oute 4 Nursi ne of Injury 28c. Injury at Work?	ng Home 5 Residence 28d. Describe how injury or	
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Division or pital or Attending ours after death. teral Director: Aft filled in by the func	3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, farm		28f. Location (Street and N	number or Rural Route Number, City MD Rd. Apt 101 Rosedale,
Lospita 4 hours 4 hours 2 uneral	20a Certifier	(Specify) found at hor	De occurred at the time, date and place, and		
Division To the Hospital or Attent within 24 bours after death To the Funeral Director: completely filled in by the	(Check only one) 2 Medical Examiner: On and		estigation, in my opinion, death occurred		
F 3 F 5			29c. License number		signed (Month, Day, Year)
	Donna Mulincand		O.C.M.E.	Januar	y 13, 2008
	30. Name and address of person who comp Donna M. Vincenti, MD Ass	eted cause of death (Item 23a) istant Medical Examiner	111 Penn Street, Baltimore, M	ID 21201	
Stat Registra	2000	32. Pogistrar's Signature	Sneeth)		
1.0915110	NAM T # FOOG	I SHEETING ST. ST.			

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Month GIBBS TANHAFY 2008 DONALD 09 4c. County of Death City, Town, for Location of Death Facility Name (If not institution, give street and number) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours 1 ▼M 2 □ F 49 219-74-8240 5-14-1958 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Y☐Yes 2☐No N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S A 14. Race - American Indian, 517 Dolphin Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZINo Specify: Specify: Black 3 ☐ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Unk College (1-4or 5+) Elementary/Secondary (0-12) Temp Service 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald W. Gibbs Vera Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11113 Copeland Ct Frederickburg VA 22407 Tyrone Gibbs - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Trinity Cemetery | 1-15-2008 | Baltimore, MD 4 Donation 5 DOther (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East MD 21202 Avenue Balto, 1101 E. North Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only consume ause on the line. Immediate Cause (Final -1001 disease or condition resulting in death) Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. 2010 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 □ Yes 2 □ No 2□No

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

ပ

Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans attending properties of the second To the Funeral Director; After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacl

Completed by Physician/Medical

Be

Medical Certification: To

or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant

25. Was case referred to medical examiner?

5 Pending investigation 6 ☐ Could not be

determined

1 hpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifie

1 Yes 2 211 Ho

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) JAN 14

32. Registrar's Signature

Registrar

State

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi the Hospital

State Registrar

Medical

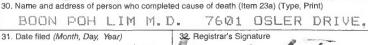
31. Date filed (Month, Day, Year) 2008

4

29b. Signature and title of certifie

29a. Certifier

(Check only one)





🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D37254

TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ITZHAK JANUARY 10:05A GREENBERG 2ŎÖ8 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. 212-78-4755 1**X** M 2 ☐ F Mrth 23/1912 95 ROMANIA Yrs Director Usual Besidence of Decedent 10c. City, Town or Location show 10a, State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Hean 23s or 28s-f show Important: If Hean 27s Is marked other than "natural", or Items 23s or 28s-f show any InJury or other traumatic event, the Medical Examiner must be notified as 1 XYes 2 □ No MD Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5715 PARK HEIGHTS AVENUE, # 301 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married
Widowed 4 Divorced Saltimore, Maryland 21215-0036 1 Yes 2 No Specify 2 Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** CASSEL FOODS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMON GREENBERG DORA UNOBTAINABLE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORENA SHAPIRO / DAUGHTER 555 S. ATWOOD ROAD #426 BEL AIR, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BETH JACOB CONG. 01/11/2008 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3000 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner married Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 1 Natural 28a. Date of Injury After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) 5 Pending investigation within 24 hours after death. To the Funeral Director: 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

08-00151 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michele Lee Hugel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ January 5, 2008 Medical Examiner Michele Lee Huge] 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14808 Hanover Pike **Baltimore County** Upperco If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Director 29 May 213-92-5122 1 M 2 **X**F 36 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Arbutus Baltimore Director 10e. Street and Number 10f. Zip Code 21227 1414 Knecht Avenue Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X No Yes Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 17. Father's Name (First, Middle, Last) Collins Lena Isaac Coles 19a. Informant's Name/Relationship (Type, Print) Lena Coles - Mother 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State 01-10-08 Meadowridge Mem. Park Donation 5 Other Specify: Signature of Fuperal Service Licenses 22. Name and Address of Facility Inc **Physician** failure. List only one cause on each line. /Medical Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED attending physician a for use as the burial -#250,1711,27,28a-f, perME,g876, IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown ned by the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cocaine use Completed 24a Was an autopsy performed? ✔ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or oreian 1971 Country) MD 10d. Inside City Limits 1 Yes 2 X No 10g, Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify 16b. Kind of Business/Industry N/A 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Knecht Ave., Baltimore, Maryland 21227 Elkridge, Maryland Gary L. Kaufman Funeral Home at 7250 Wash. Blvd., Elkridge, MD 21075 art I. Enter the disease 🖋 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Year Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available pnor to completion of cause of 1 🗸 Yes uneral director. Be Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient ER/Outpatient 3 DOA this 1 Yes 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Natural Yes 2 X No within 24 hours after death. To the Funeral Director: the Pending Fnd 1/5/2008 Fnd 10;00 pm 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 14808 Hanover Pike, Upperco, MD determined (Specify) house 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 6, 2008 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 2008 Registra

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

3-Time of Death

2250 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Edna May Hughes PΜ January 2008 /Medical 7:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens - Charlestown Catonsville Baltimore 9. Birthplace Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** 1 M 2 F Hours Months Days 556-40-3767 Director 105 12/28/1902 England Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ¥No Directo Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7105 Maiden Choice Lane #105 21228 Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ρ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Rice Emily Dart ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: if Item 27 is any Injury or other trau Lois M. Hughes / Daughter-in-law 3309 Densmore Court Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 01/11/2008 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, MD 21. Signature of Funeral Service Licensee Mark T. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate ha 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 2 No funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 971 10ider 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day A M Henri Harmon, Sr. January 10, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard 7611 Singer Drive Jessup If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Feb. 18,1929 Social Security Number 9. Birthplace (State or Foreign 1**X** M 2□ F 78 Maryland 212-30-7138 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7611 Singer Drive 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harmon Anna Schaub 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Harmon Wife 7611 Singer Drive; Jessup, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 1-15-2008 Baltimore, Maryland 4 ☐ Donation → Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signatur of meral Service 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) overseulen ypertensine N Due to (or as a consequence of): undiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical **Examiner** Examine the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be ပ္

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Attending Physician:

sician and burial-trans attending physician for use as the buria ned by the a signed I peen cate has l director,

this certificate funeral (After

Physician/Medical Completed Be 2

29a. Certifier

Certification: To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: At completely filled in by the fu

2	
Sta	ite
Registr	ar

Medical

29b. Signature and title of certifier Saumon

2008

JAN 1

29c. License number H36245

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington Bird Elbridg MP 21075 5841 BB Aumon 31. Date filed (Month, Day, Year)

32. Registrar's Signature

🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 - 2008 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Kandallstown Genesis if Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2□F Hours 017-24-3447 Yrs. 75 Director 05 Dec. Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medica Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Liberty Road 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Record Company Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Herbert Esther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Clara Inners (Friend) 7903 Hilltop Ave, Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State January 12 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 2008 Baltimore, Maryland 21. Signature of Funeral Service Literis W. Dabrowski/Chojnacki Funeral Homes P.A. ash (1005 Dundalk Ave. Baltimore, Maryland 21224 23a. 6 rt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Advancea resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any boding to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 0 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Thursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Medical 29a. Certifier Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Ye

Year)

Liberty Road, Randallstown, MD 21133

State

amend item 3 per doc 2875 1-24-08 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan 11, 7:30 P_M **Physician** Elva Madeline Jenkins 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster CArroll CArroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Birthplace (State or Foreign Country) 1□M 21 F 86 Days Hours 210-20-7650 30, Director May 1921 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notifled at 1 ☐ Yes ŽŽNo Director Bedford Bedford PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 498 Sweet Root Rd. 15522 United States 'natural', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify Specify: Completed by 3℃Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Double T Diner Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Addison Boore Carrie P Beegle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Mathias Lane Mt. Airy, MD 21771 Carole Lamb (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bedford County Mem Park 1/16/2008 Bedford, PA 4 □ Donation 5 □ Other (Specify) permit. 22. Name and Address of Facility
Burrier—Queen Funeral Home and Crematory,
1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2 **□** No 1 Tyes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has , page performe certificate 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပို 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (W Registrar's Signature ionth, Day, Year) Registrar 4 ZUUŏ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 7,8, perFH, 0875, 1/17/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/12/2008 **Physician** Melvin Charles Jones 4:11 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 2/28/1917 9. Birthplace (State or Foreign (Month, Day, 2/28/1917) **Funeral** Days Hours 1 M 2 □ F 79 213-07-4900 90 Director 1928 | Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 Bella Vita Ct. 2D 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced fileo ...
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d other than "natural"
the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Management Bethlehem Steel traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be William Jones Anna Toeffner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Jones (wife) 26 Bella Vita Ct 2D Westmisnter, DM 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 1/14/2008 Winfield, MD 21. Signature of Euneral Service Licenses 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 2178/Approximate the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immédiate Cause (Final disease or condition resulting in death) ASHD **Physician** Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IE EEMALE nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 200 No page Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUS S Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or After...
irs after death.
rai Director; After After 1 Natural 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D ExertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061755 30. Tame and address of person who completed cause of death (Item 23a) (Type, Print) 14

Registrar

State

HEMALATH A

2008

31. Date filed (Month, Day, Year)

Mark C

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32. Registrar's Signature

700A POOLE RD WESTMINSTER, MD 21157

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Fund Direct			5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SEPT	, Year)	9. Birth	place (State or Foreign SKTH AROLINA
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the Ma	notified	Director	MD . N/A		BA	LTIMORE 10f. Zip Code	CITY	1	l0g. Citizen of W	hat Cou	1 ☐Yes 2 ☐ No X
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the dear	ached fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			IVIO		Day Teal
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VITAL HECOFICS, sician: The law requires t certificate has been signe	2 shou	Completed by	Manutrition					24a. Was a	an 24b. 1	Nere aut	topsy findings available ompletion of cause of
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DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	d in by the	Certification:	2 Accident 3 Suicide 4 Homicide 1 Homicide	28e. Place of inju building, etc	rry - At home, farm, s c. (Specify)		-	28f. Location (S City or Tow	Street and Numb vn, State)	er or Ru	ral Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00524 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1805 01-08-2008 Maria Kanaras /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Conowingo Reinholt Asst. Living Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-06-1927 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕅 F Yrs. 80 Greece Director 072-24-8917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthen "naturel", or iteme 23s or 28e-f ehov The Medical Examiner most be notified at 1 Yes 2X No Cecil Port Deposit Maryland Direct 10g. Citizen of What Country? 10e Street and Number U.S.A. 95 Nicholas Alexander Drive 21904 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) reath and Mental Hygiene.
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1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed HYPERTENSION 2 No Physician: 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No nerel Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours a To the Funerel Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BEL AIR 2 NO RITH M. ABMYANKAR 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Pearl Knight 18:44 P M 01-09-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗙 F Director 220-24-8151 94 09-10-1913 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Harford Whiteford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or 4105 McNabb Rd U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7; h and Mental Hygiene. **7 Is marked other than "n**. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 J.W. Reaser <u>Estaline (Unknown)</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 Is any injury or other trauonce. Loretta Crovo (Daughter) 4105 McNabb Rd Whiteford, MD 21160 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 01-14-2008 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Renal Immediate Cause (Final disease or condition resulting in death) tailine **Physician** Acute ~ 24 hours /Medical Due to (or as a consequence of) **Examiner** Swock hic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed ostrium and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dosis 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20066136 10/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESAPEAKE DR., BEL AIR, MD 21014 MUHENDU 500 UPPER 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

KNIGHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year hevin an 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimore Maryland Medical Center If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year, 9. Bifthplace (State or Foreign **Funeral** $Q_{\square F}$ Months Maryland 212-96-2771 Usual Residence of Decedent Hours Director with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits The marked of the than "natural" or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Directon** 10f. Zip Cod 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or many Injury or other traumatic event. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, ို 19a. Informant's Name/Relationsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Maryan 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service Lipens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dayo Depsis /Medical Due to (or as a consequence of): Examiner cineto bacter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d Date of delivery 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 200 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 000 1 Tes Other: 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Datural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) South 2 1 reakle Greene edistrar's Signature 31. Date flied (Month, Day, 32 State Registrar **JAN 14**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN Day Year **Physician** 2008 6:10AM 09 Anne I. Lister /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT AGNES HEALTH CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🕌 220-66-0048 94 May 10, 1913 Ireland Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2KINo Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Mill Town Court 21228 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: Specify: 2 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James O'Malley Mary Campbell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Mill Town Court; Catonsville, MD 21228 James P. Lister Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 1/11/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Puperal Service Licens NO1290 1630 Edmondson Avenue; Catonsville, MD 21228 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ire. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart fraire. Immediate Cause (Final ACUTE CORONARY SYNDROME ONE HOUR disease or condition resulting in death) CORONARY ATHEROSCLEROSIS MANY YEARS secus daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine DEIZURE DISORDER MANYYEARS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No TRACT PRINARY TNFECTION. 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 🗌 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Prakasa

Records, P.O. Box 68760 Vital the Hospital or Attending Physician: 0 U sion (24 hours a

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any Inportants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical Examiner

attending pl

has

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAFF OFFICE I ST. AGNES HEALTH CARE KALPANA PRAKASA, MEDICAL STAFF OFFICE I ST. AGNES HEALTH CARE GOO CATON AVENUE BALTIMORE MO-21229 31. Date filed (Month, Day, Year) .32. Registrar's Signature State 4 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Dana

MD.

10059554

JAN 09, 2008

		For State Registrar	State of M	laryland /	-	artment of F		nd Mental H	Hygiene.	211118	00528
Physi /Med		Decedent's Name (First, Middle, SALLY	Last)			L.	AU	2. Date of JANUA	Death	2008	3. Time of Death 12:10P M
Exam	iner	4a. Facility Name (If not institution, GENESIS CATON N 5. Social Security Number	MANOR NURSI			4b. City, Town, o	ALTIMO	RE	Righ	County of Death BALTIN	10RE
Funera Directo		129-14-6388 Usual Residence of Decedent	1□M 2MF	82	Yrs.	Months Days	Hours	Min. (Month)	Day, Year) 4/1925	5	place (State or Foreign ntry)
72 hours after death with the Maryland ratural", or items 23a or 28a-f show dical Examiner must be notified at	Director		IMORE	10c. City, To	own or Lo	ORE					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
eath with the same same of 2 must be no	Funeral Dire	3330 WILKENS A	AVENUE 12. Was Decedent	t Ever in II S	12.1		21229	in? (Specify Vec ex		usen of What Cou USA 14. Race - Ameri	
ours after d ral", or item Examiner	b	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🛣 Widowed 4 □ Divorced	Armed Forces	2 No		f Yes, specify Cub	an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)		Black, White	
	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or		(Give	dent's Usual Occup kind of work done DO NOT use retired HOMEMA	during most d)	of working	16b. Kir	nd of Business/II	
ar yidanid 2 12 should be filed with and Mental Hygiene, marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, L	.ast)		WEXL	ER	18. Mother	's Name <i>(First, Mic</i>	ldle, Maiden l	,	AINABLE
and 2 sho ealth and 1 n 27 is ma	ľ	19a. Inf HARRY am Deetal Alf						Sadirak Boute No VENUE, BA	G ^{ber,} Be1	To Ki S tate, M	87.0021214 21206
Deficiency, IN permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				sition (Name of matory or other place ISRAEL		Date 1/13/2008	s woor	DBRIDGE	, NJ
permit. Pag Department Important: I any Injury c	5	21. Signature of Funeral Service I	Mam	ex			STERST	OWN ROAD	- PIK	& BROS ESVILLE	., INC. , MD 21208
Physiciar /Medica	-	23a. Part1. Enter the disea , shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that causonly one cause on each	d the leath. D	P a	er the mode of dyir	ng, such as o	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
Examine	١.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Co20	s a consequent o Move a a consequent	7	Aster	1	Discon	e		years
or ou, cate be executed ohysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ane. Due to (or a	s a consequen	ce of):						moners
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending picompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2 □ Fetal de at time of death	ath 3	Ectopic pregnanc Other <i>(specify)</i>	y		_ 2	23d. Date of deline Month	very Day Year
equires that en signed b	þ	Part II. Other significant conditio	ns contributing to death	but not resultin	g in the u	nderlying cause giv	ren in Part I.				the cause of death?
ding Physician: The law range. After this certificate has be funeral director, page 2 shr	Completed							l a	Vas an autopsy erformed? es 2 No	24b. Were aut prior to c death? 1 ☐ Yes	copsy findings available completion of cause of 2 No
sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			oth	or	of Death (Check or			
g Phy ter this	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of In (Month, D	jury 28	b. Time o	IL 3 L DOA	Nur	sing Home 5 🗆 F 28d. Descr	Residence 6 ibe how injury		ify)
l or Attendir after death. Director: Af	Certification:	Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could n 4 Homicide determine	ation of be 28e. Place of ir				Yes 2□N	28f. Location	on (Street and Town, State)	d Number or Ru)	ral Route Number,
he Hospita n 24 hours he Funeral pletely filled	edical C	29a. Certifier Certifying (Check only one)	g Physician: To the bes Examiner: On the basis and manner s	of examination	and/or in	vestigation, in my	opinion, deat	h occurred at the ti	me, date and	place, and due	to the cause(s)
Within Con to t	Σ	29b. Signature and title of certifier	00 0 00			29c. Licens	e number	. []	29d. Date	e signed (Month	, Day, Year)
27		30. Name and address of person v	who completed cause of	death (Item 23	a) (Type,	Print)	2 2	130	3717	7 10	01vmbce
	tate	Shakun MA 31. Date filed (Month, Day, Year)	1-A GUP 32. Regis	trar's Signature	7650	best 1	refe	D MQ 0	ute	2 110	2008 2008 010mble 140 21045
Regis	strar	JAN 1	7 7000	Side State of the	17	3					

DHMH 17 Rev 1/2001

08-00210 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brian Keith Mikesell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day January 7, 2008 Year 2315 hrs **Medical Examiner** Brian Keith Mikesell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Waldorf Charles 1744 Brightwell Ct. 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Wash., DC Months Days Hours Min Director 214-78-5071 02/17/1978 1X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: 1f item 27 is marked other than "natural", or items 23a or 28a-f shoingray or other traumatic event, the Medical Examiner must be notified at once. Maryland Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? Direct 10f. Zip Code 1744 Brightwell Court 20602 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married Yes 2X No Widowed Divorced f Yes, Give Yea Yes 2 X No specify: Specify: White δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Cashier Food Mart 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brian Dudley Mikesell Brenda Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Klingebiel- mother 2413 Countryside Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date timore, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 1/10/2008 Alexandria, Virginia 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleck Funeral Home, INC. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland 20707 Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED #23a.27 attending physician for use as the burial perME,0876, 2/1/08 TT 28a-f. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed be ⋧ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? Yes 2 No 1 🗸 Yes 2 No certificate the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 V Other: Scene After this Inpatient 2 ER/Outpatient 3 DOA 1 Yes ို 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 X No Natural Director: Pending unk Fnd 1/7/2008 Fnd 11:00 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide To the Funeral D 1744 Brightwell Ct. Waldorf, MD determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME

Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

State

Assistant Medical Examiner

32. Egistrar's Signature

and address of person who completed cause of death (Item 23a)

2008 4

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Murphy, Jr. 6:00 Kenneth January 6,2008 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14808 Hanover Pike Baltimore Reisterstown Sex 14 M 2□F if Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 12/15/1963 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 217-84-7414 44 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 No Reisterstown Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14808 Hanover Pike 21155 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1X Never Married 2 ☐ Married 1 □ Yes 2 No Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Surveyor Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Kenneth A. Murphy, Sr. Dorothy E. Goetz in and 2 shu int of Health and Me artant: If item 27 is " ny injury or other" 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2199 Stoney Valley Dr., Manchester, MD 2110 Dorothy E. Murphy (Mother) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Glen Haven Memorial 1/11/08 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5yn Physician -Monic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Attending (Month, Day Year) 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number D0036112

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4231 Northwoods Trail Hampstead NAD 21074 Alexander M D 4231 / 32 Registrar's Signature Kocha

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #6 State of Maryland / Department of Health and Mental Hygiene Per FH G875 1/16/08 III Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:15p 11 2008 Carneal Watson McNeil/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Future Care If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 4-24-1934 Birthplace (State or Foreign Country) Social Security Number Funeral 1X M 2XX N.C. Director 73 244-52-6366 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director N/ABaltimore MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2534 W. Lanvale Street 21216 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Black, White, etc. Armed Forces within 72 hours after I ☐ Yes 2 XNo f Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) N/A N/A than. Elementary/Secondary (0-12) College (1-4or 5+) ages 1 and 2 should be filed wi ent of Health and Mental Hygier nt: If item 27 is marked other th y or other traumatic event, the Years 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Watson 2 Duncan McLean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 2534 W. Lanvale Street Baltimore, MD 21202 Elaine Watson Berry
20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Marial 2 ☐ Cremation 3 ☐ Removal from State 1-18-2008 Rowland, N.C. Aaron Swamp Bap 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to lor as a consequence of): **Physician** /Medical infection **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-Box 68760. attending physician Physician/Medical the as IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, **∂** 2 ZNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy page 2 performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2**⊠** No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

413 Comm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

un

32. Registrar's Signature

B.

JAN 14

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY Year **Physician** OHN 19:55 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CIT HOPKINS HOSPITAL JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 78 214-24-1153 Director July 15,1929 MD. Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Manyland th and Mental Hygiene. It am a marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD. Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2025 Greengage Rd 21244 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering Technician Engineering permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John S. Morrison TT Mabel Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ethel H. Morrison 2025 Greengage Rd. Catonsville, Md. 21244 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Jan.12,2008 Baltimore 21. Signature of uneral Service 22. Name and Address of Facility 9705 Belair Rd. Schimunek Funeral Home, Inc. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ELECTROLYTE ABNORMALITY INCLUDING HYPERKALEMIA DAY **Physician** /Medical Due to (or as a consequence of): Examiner FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed HEPATIC FAILURG physician and s the burial-tran Due to (or as a consequence of) Box 68760, GALLBLADDER Physician/Medical attending physical for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 I Inknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an ate has t page 2 s autopsy performed? Yes 2 No certificate I 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 ☐ Yes 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t To the Hospital or Attending 5 ☐ Pending investigation Injury 1XXNatural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12 1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

BALTIMORE MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	iryiand		artment of H rtificate of L			leg. No 200	8 00533
	Physicia	an	1. Decedent's Name (First, Middle, L						Date of Dea Month	th Day Ye	3. Time of Death
60 0 20 0	/Medic	al	WILBERT W. McLE(4b. City, Town, or	Location of Death	JANUARY	7 08, 2008	
	Examin	er	SOUTHERN MARYLAN		CENT	ER	CLIN				GEORGES
	Funeral			Sex 7. Age	(In yrs. lasi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAR • 27	Year) 9.	Birthplace (State or Foreign Country) DUTH CAROLINA
L	Director		247 98 7392 2 Usual Residence of Decedent		54	Yrs.			MAR. 27	, 1953 S	OUTH CAROLINA
	ryland how at		10a. State 10b. County		10c. City, T	Town or Lo	cation				10d. Inside City Limits
	8a-f s	Director	MD CHARLI	ES	WALI	OORF					MXYes 2 □ No
	with the a or 2		10e. Street and Number 5028 BASS COURT				10f. Zip Code 2060	2	1	Og. Citizen of Wha	•
	death ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13.	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-		American Indian,
036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes ※ If Yes, Give Year or Dates:	lo		1 Yes, specify Cubai		Rican, etc.)		Vhite, etc. BLACK
Maryland 21215-0036	hin 72 ho e. an "natul Medical	Completed	15. Decedent's I (Specify only highest g	ducation rade completed)	I 1	16a. Deced (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ation Juring most of worki	ng	16b. Kind of Busin	ess/Industry
121	filed within 72 Hygiene. Ither than "nat	omp	Elementary/Secondary (0-12) 12TH	College (1-4or 5-	+)		O BUS OPE			METRO	/WMATA
פר	be filed wit ntal Hygiene d other tha event, the	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	(First, Middle,		
<u>ya</u>	2 should b and Menti is marked aumatic e	To E	JOHNIE LEE					FRANKIE			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship BEVERLY McLEOD				ig Address <i>(Street a</i> HOPE CIRC			r, City or Town, Sta ID 20601	te, Zip Code)
	es 1 and 2 should k of Health and Ment (tem 27 is marked r other traumatic		20a. Method of Disposition				sition (Name of natory or other place		Date 1	20c. Location - City	or Town, State
Baltimore,	Page nent nr: II		XXBurial 2 □Cremation 3 4 □Donation 5 □ Other (Spec	ify)	1	ITY M	EMORIAL G	AR. 01/18		WALDORF	-
Ra	permit. Departrr Importa any Inju	b	21. Significance of Fundinal Service Lice	insell		M 4	Name and Addres ARSHALL'S 308 SUITL	s of Facility FUNERAL AND ROAD	HOME OF	MARYLAN ND, MD 20	D, INC. 746
			23a. Part 1. Enter the disease, or consheet, or heart failure. List onl	nplications that caused one cause on each line	the death. I	Do not ent				est,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immedia Cause (Final disease or condition resulting in death)	a. Due to (or as a	whe /		ivehal Ir	twitin			
	Examiner			Hype	rtensi		feunt Dix	less			
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o) as a	consequen	nce of):					
	execution and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequen	nce of):					
09/89	tificate be executed g physician and as the burial-transit	edical E		▲ d							
	ertifica ing phy		IF FEMALE:								
C. Box	w requires that the death certific been signed by the attending f should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
7.	that the		Part II. Other significant conditions	contributing to death bu	t not resultin	ng in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
spu	equires en sigr	ed by							1 □ Y	es 2⊡-No 3[Probably 4 Unknown
I Kecords,	The la ate has page 2	Completed							24a. Was a autop: perfor	sy prior med?_ deat	
VITa	Physician; this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Tours	26. Place of Death	(Check only or	ne)	
_	S .20	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatier		Outpatien Bb. Time of	t 3 DOA Othe	4 ☐ Nursing Ho		ence 6 Other (Specify)
0	ath. rr: Afte	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day on	Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ No			
ທ	or Atter tifter des Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of injurbuilding, etc.	ry - At home . (Specify)	e, farm, str	eet, factory, office		28f. Location (S. City or Tow	treet and Number on, State)	r Rural Route Number,
DIVISION	S S S	8			f mv knowle	edge, death	occurred at the tim	e, date and place	and due to the c	ause(s) and manne	
DIVI	ne Hospital 24 hours a ne Funeral sletely filled		29a. Certifier 1 Certifying P	hysician : To the best o miner: On the basis of and manner stat	examination	n and/or in	vestigation, in my op	pinion, death occur	ed at the time, o	late and place, and	er as stated. due to the cause(s)
NIO)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	(Check only 2 Medical/Ex	miner: On the basis of	examination	and/or in	vestigation, in my op 29c. License	oinion, death occurr number	ed at the time, o	date and place, and	due to the cause(s)
NIA	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Fixone) 29b. Signature and title of cylinery	miner: On the basis of and manner stat	examination led.		29c. License	pinion, death occurr	ed at the time, o	9d. Date signed (M	due to the cause(s) fonth, Day, Year)
NIO)	To the Hospital within 24 hours a To the Funeral i		(Check only 2 Medical 2)	Iminer: On the basis of and manner state. Implication of the basis of the and manner state. Implication of the basis of the basis of the and manner state.	examination led.	Ba) (Type,	29c. License D 0 0	oinion, death occurr number	ed at the time, o		due to the cause(s) fonth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:37 PM ELVA MCDANIELS. JANUARY 2008 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rose Manor Assisted Living Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 8, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 28 F Days Hours Yrs. 94 Massachusetts 023 16 1785 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 3100 N. Ridge Road #117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? I ☐ Yes 2 ██No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Colburn Anna Hauck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2704 Snomill Court Ellicott City, MD 21043 Elinore Kuebler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1-11-2008 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA 14 DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) 1 act Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ons contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No SION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living A Citil Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificete be executed

Physician

/Medical

Examiner

Completed by Funeral Director

Be

MD

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-4 shours injury or other traumatic event, IIIs Marganel.

the burial-transit To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fun

Division of Vital Records, P.O. Box 68760,

Ilcal Ex	resulting in death) La	st
ysiclan/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 🖼 9 □ Unknown	ionths?
Be Completed by Physician/Medical Ex	Part II. Other signific	
To Be C	25. Was case referre examiner?	,
Sertification: To	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide	5 Pendir investi 6 Could determ

amlne 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury ng gation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) to the cause (s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PHYSICIAN.

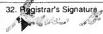
D0063166

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 10 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 720 C MAIDEN CHOICE LANE CATONSVILLE MD 21228 DR.MERCY TACKEON

31. Date filed (Month, Day, Year)





State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 01 2008 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayurew Medical Center Johns Hankins
5. Social Security Number Baltimore
If Under 1 Year If Under 24 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F 93 Director 213-05-5246 July 17, 1914 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Yes 2 No Baltimore Directo Mary AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be n Bouldin Street U.S. A 109 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Honomarex OUN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be inent of Health and Mental Int: If Item 27 is marked o DIVENS 2 AYMOND 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Alto LAVERNE permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BAltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) -16-2008 21. Signature Funeral Service Licenses Kar 5+ liva 23a. Part1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death plications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anzuminia Due to (or as a consequence of): Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 | Yes 2 | No 3 | Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ EN/Outpatient 3 ☐ DOA 1 Yes 2 1 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

State Registrar 25

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend istane 11 Mary latter / 18875 aritml At 08 Haztith and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 008 **FLORENCE PASS** CLAMARY G /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Honore N/A 0 8. Date of Birth 06/07/1916 Birthplace (State or Foreign
 Ountry) 5. Social Security Number Say **Funeral** 1 □ M 2 🔭 F 214-03-6635 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 SLADE AVENUE, #609 21208 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) the **SECRETARY** DRY WALL CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORRIS **AMERNICK PEARL** MEDNICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Is n or other traun STUART PASS / SON 1 DORSET HILL ROAD, OWINGS MILLS, MD 20b. Place of Disposition (Name of cometery, crematory or other place HAGUDHAMEDROSH 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4⊟Donetion 5 ☐ Other (Specify) 01/11/2008 ROSEDALE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Juneral Service Littens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ongestive. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examinet the Hospitel or Attending Physician: The law requires that the deeth certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part IJ, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ronari 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 - atural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funerel Director filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 MBBS. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Day, Year)

32. Registrar's Signature

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Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ALLIE RAYMOND 01 10 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CTR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days 1 ☐ M 2 🕽 F 21358 1944 MAR I LAIVE Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No BAITIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3233 Ravenwood Ave. 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVET ENVIRONMENTAL SERVIKE 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3+ 5+ BAlto $m_{\mathcal{S}}$ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/19/2008 BAITIMORE 4 □ Donation 5 □ Other (Specify) Phaneland Address of Figure 1 EATH & FOR & FUNELAL HOM 2431 F. Oliver St. Baltomo 21213 21. Signature of Funeral Service Licensee 23a. Part1. En er the disease, or comunications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY 20 YEARS 20 YEARS CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CHRONIC KIDNEY DISEASE Due to (or as a consequence of): 23d. Date of delivery Month Year se contribute to the cause of death? 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) d Number or Rural Route Number,

Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral D

Physician

/Medical

Examiner

10a. State

Funeral

Director

or 28a-f show notified at

"natural", or items 23a or

Department of Health Important: If Item 27 any injury or other tr

Physician

/Medical

Director

Completed by Funeral

Be

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Y
Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the cause of de 2 □ No 3 Probably 4 □ U
				24a. Was an autopsy performed:	
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2X No	Hospital: 1 Inpatient 2 □]ER/Outpatient 3 ☐ □	OA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, St	and Number or Rural Route Numbate)

JESSICA COLBURY, M.D. JHBMC 4940 EASTERN AVE. BALTIMORE, IND

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

01/10/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Selekof Miriam 1:00pm 2008 January 13. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pikesville Baltimore Sunrise Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Year) Months 057-03-7050 1 ☐ M 2 ☐ XF 90 Yrs. June 26 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Pikesville 1 ☐ Yes 2 → No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 3800 Old Court Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 □ Yes 2 Ϊ No Completed by 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) city government secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Rosenblum Lottie Weiss ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7322 Bobolink Court, Columbia, MD 21046 Joel Selekof (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1-16-08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth E1 Cemetery Washington Twp., NJ 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Dauge Saight P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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coext Rd - Soite 301,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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4000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day} 2008 **Physician** Perry Jonathan Suter 2:25 P M Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll New Windsor 3530 Doberman Dr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 9, 1974 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1**⊠**M 2□F 33 Director 218-02-8368 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No MD Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 3530 Doberman Dr. United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White <u>ک</u> 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Skips Auto Collision Elementary/Secondary (0-12) College (1-4or 5+) 12th Auto Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Martha M. Cugle Francis P Suter, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3530 Doberman Dr. New Windsor, MD 21776 Stacey Suter (wife) of Health 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or or S. Carroll Crematory 1/15/2008 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar re of Funeral Service Licensee 22. Name and Address of Facility
Burrier—Queen Funeral Home and Crematory aus 1212 W. Old Liberty Rd. Winfield, MD 21784 23. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown, or heart failure. List only one cause on each line. Immediate Cause (Final Round Physician omall disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 9-10 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at tîme of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð cate has been si, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 □ D0A After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After Certification: Division 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suîcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 4 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Michael A. Carclucci M.D

JAN 1

31. Date filed (Month, Day, Year)

Broadway Baltmore MD 2/231

401 North

32. Registrar's Signature

Baltimore, Maryland 21215-0036

			for State Registrar	State of Maryia		ertificate of		-	GIETT Reg. No	2000	00541
'n	Physici	¢ an	1. Decedent's Name (First, Middle, Las		`			2. Date of De Month	ath Da	ay Year	3. Time of Death
	/Medic		Uahn		per	Cest	al and a of Dooth	Janua	Ny	10 200	
	Examin	er	4a. Facility Name (If not institution, give			1	r Location of Death		42	County of Deal	in
	Funeral	-	5. Social Security Number 6. Se	x 7. Age (In yr	s. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bird	th Van	9. Biti	bplace (State or Foxeign
-	Director		218-34-5661 1 Usual Residence of Decedent	X M 2□F 91	Yrs.	Months Days	Hours Min	March 12			and
	yland now at		10a. State 10b. County		City, Town or	Location					10d. Inside City Limits
	e Ma 3a-f s tiffied	ctoi	Maryland Montgomer	у (Gaithers						1 ☐ Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 301 Russell Avenue			10f. Zip Code 20877			10g. C	itizen of What Co SA	ountry?
	tems er mi	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Ame Black, Whit 	
Maryland 21215-0036	ours afte rral", or it Exa⊡ln	b	1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No				Specify: W	hite
5-("natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of work	ing	16b. l	Kind of Business	Industry
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lan/	ald be fental rked ric ev	To Be	Robert William Spence	r			Elizabeth	Marriner			
ary	2 should be frank Mental His marked of aumatic ever		19a. Informant's Name/Relationship (7	ype. Print)	19b. Ma	ailing Address (Street	and Number or Rui	ral Route Numb	er, City	or Town, State, 2	Zip Code)
	1 and 2 Health em 27 I		Richard C. Moats- Fri			Lexington Dr					
Baltimore,	permit. Pages 1 Department of H Important: If Itel any Injury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, c	sposition (Name of trematory or other plantan Cremator	ce)	2, 2008		Location - City or K andria, V	
Balt	permit. Pag Department Important: any Injury once,		21. Signature of Funeral Service Licen	mo/234		22. Name and Addre Fleck Funera 7601 Sandy S	1 Home, INC	laurel M	farv1	and 20707	
ő	4)		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the de						0.114 20.01	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alin Due to (or as a conse	nced	Brist	ife Cer	neer			Onset and Death
Ľ	Examiner		Sequentially list conditions	b							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):						
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):						
68760,	icate be executed physician and s the burial-transit				544000 0.,.						
687	tificate ig phys as the	edical		d							
.O. Box	atth cer attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death	3 □Ectopic pregnanc 5 □ Other (<i>specify</i>) _	у			23d. Date of de Month	livery Day Year
9	that the denet by the stacked		Part II. Other significant conditions of	ontributing to death but not re	esulting in the	e underlying cause giv	ven in Part I.	23e. Did t	obacco	use contribute to	o the cause of death?
Records,	w requires been sign should be	ed by					· · · · · · · · · · · · · · · · · · ·	10	Yes	2 □ No 3 □ P	robably 4 Honknown
eco	law re as bee 2 sho	Completed						24a. Was		24b. Were a	utopsy findings available completion of pause of
<u>m</u>	(0 17	Com							rmed?	death?	_ /
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hamital.			26. Place of Deat	th (Check only o	опе)		
or	8 8	T ₀	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpat	ilenii 3 DOA		ome 5 ☐ Resi 28d. Describe		6 □Other (Spe	ecify)
no	ffer ne	tion	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injur	y Wo	rk?]Yes 2 □ No	20d. Describe	now inj	ury occurred	
Division	Attending ir death. ector: After by the fune	fica	3 Suicide 6 Could not be	Zoe. Flace of injury - At	home, farm,						ural Route Number,
Ö	tal or s afte al Dir	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cny)			City or To	wn, Sta	re)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (ysician: To the best of my k niner: On the basis of exami and manner stated.							
	To th withii To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
	4		Mills	Juns		Da)59423	(Jan	wary 1	900s 1
4	1) 4		30. Name and address of person who	completed cause of death (It	em 23a) (Typ	4	7		4	0	
	V	to	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	HUR Oa	ether be	ng,	(10)	508	<i>†</i> +
	Sta Registi			008	de .	Coast		9			
			Alm I Z =	An Of the section	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

		-	1 - For State of Maryland / State of Maryland /	Department of Health and Me Certificate of Death	ntal Hygiene
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death
	Physicia		BONNIE SHIRK		ANUARY Day 14, Zear 1:45 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			FRANKLIN WOODS GENESIS	450SEDALE	BALTIMOCE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last by 216-24-3443	virthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. 1	3. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) W. VIRGINIA
	Director		Usual Residence of Decedent		1-20-1920 W. VIRGINIA
	yland		7	wn or Location	10d. Inside City Limits
	e Mar	ctor	MD BALTIMORE	ROSEDALE	1 □ Yes 2/1 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. It has the and Mental Hyglene. It is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, Ita Necleal Ever in at Italia of the colline of the Italia of th	i Director	10e. Street and Number 1211 64th STREET	10f. Zip Code 21237	10g. Citizen of What Country? U.S.A.
	death ms 2;	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.
98	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	Specify: WHITE
Ş	hours turel',	ed by	3X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16	a. Decedent's Usual Occupation	16b, Kind of Business/Industry
7.	in 72 n "na	Completed	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	
212	e filed within al Hyglene. other than "	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	SECRETARY	ESSKAY
Maryland 21215-0036	d be filed intal Hygle ed other c event, t	Be	17. Father's Name (First, Middle, Last) FRANCIS MARION BIBY	18. Mother's Name (BESSIE	First, Middle, Maiden Sumame) C (PAINTER)
3	2 should be f and Mental H Is marked of raumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
	1 and 2 Health a tem 27 is		B. JACK SHIRK/SON 7	The second secon	SEDALE, MD 21237
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State	of Disposition (Name of Pery, crematory or other place)	te 20c. Location - City or Town, State
Ë	Pag ment tent: jury c		`4 □ Donation 5 □ Other (Specify) NORT		7-08 RIVERTON W. VA
Bal	permit. Page Department (Importent: If any injury or once.		21, Signature of Funeral Service Licensee	1211 CHESACO AVE	CH/ROSEDALE FUNERAL HOME ROSEDALE, MD 21237
	8		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac or	interval between
	Pnysician	N .		UMONIA	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence		
lia.		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence		
V	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c		
o,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence	e of):	
8760,	ate be	dicai	d		
9	eath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	atten I for us	Physician/Me	in the past 12 months?	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
0	at the de by the a tached	hysi	1 Yes 2 No 9 Unknown 9 Unknown		
S,	es that igned b	by P	Part II. Other significant conditions contributing to death but not resulting	; in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ord	w require been signature		CHF, PIABETES		1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	e law r has be ge 2 sh	ompleted			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
al H		S			1 Yes 2 No 1 Yes 2 No
Vit	Physicien: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/	26. Place of Death Other: 4 Nursing Hom	(Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)
	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b	. Time of 28c. Injury at 28	Bd. Describe how injury occurred
ion	ath. rr: Afte	atio	1 Natural 5 □ Pending (Month, Daý Year) 2 □ Accident investigation	Injury Work? M 1 Yes 2 No	
Division	or Attending ifter death. Director: After in by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	pital c		COn Continue of Continue Chamining To the Land	an death accurred at the time date and alconomic	and due to the cause(s) and manner as stated
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowlec and manner stated. 2 Medical Examiner: On the basis of examination and manner stated.		
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Vim Parsholl	D40008	1114/08
	9		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Print)	RE DR. BALTIMORE MY
	(31. Date filed (Month, Day, Year) 32. Registrar's Signature	FRANKLIN SQUA	LE TIM DATLINGIET 13
	Sta Registi		JAN 1 4 2008	Loto	

E(ea nor Staninsk)
Baltimore Marvland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State	State of Ma				t of H	ealth a			giene	$\Omega \cap \Omega$	00543
			Registrar 1. Decedent's Name (First, Middle, I				incate	- 01 1	Jeani		2. Date of De	Reg. N6	_ 0 0 0	3. Time of Death
	Physici /Medio		ELEANOR ST	,							Jan.	Day	3008	
	Examir		4a. Facility Name (If not institution, GENESIS LOCH 8720 EMGE R	rive street and number)			-		Location o			_	County of Dea	
	Funeral Director			Sex 7. Ag	e (In yrs. 80	last birthday) Yrs.	If Under Months		If Under		8. Date of Bi (Month, D			rthplace (State or Foreign country)
			Usual Residence of Decedent									1.10		
	permit. Pages t and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show with injury or other traumatic event, tra Medical Engiting must be ricitified at ODGE.	ō	Md.			y,Town or Lo timore	cation							10d. Inside City Limits YYYes 2 ☐ No
	282-	Funeral Director	10e. Street and Number		Dal	rimore	10f. Zip	Code				10g. Cit	izen of What C	country?
	with Se or	<u>ā</u>	610 S. Rose St.					1224				_		,
	leath ms 2;	era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.				gin? (Spe	ecify Yes or N Rican, etc.)		S.A. 14. Race - Am	
10	r iten	듄	1 Never Married 2 Married	Armed Forces?	No					, Puerto	Rican, etc.)		Black, Wh	ite, etc.
030	el', o	þ	3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2∐ No	Specify:				Specify:	White
5-0	72 ho natur	sted	15. Decedent's (Specify only highest of	Education		(Give	dent's Usua kind of wor	k done o	furina most	t of work	ina	16b. K	ind of Busines	s/Industry
21215-0036	ithin 19	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired)			77	1 -	
2	led w lygier her th		6			House	wite	1	40 Marks	oda blassi	- (Fire & Adiabati		memake	r
Maryland	Id be fi ental H ked ot Ic ever	To Be	17. Father's Name (First, Middle, La - Albert Sova						Mar		e (First, Middle Unkr		Sumame)	
E Z	shou nd M mer	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	r or Rur	al Route Numb	er, City	or Town, State,	Zip Code)
	atth a		Albert E. Stawi	nski		9609	Haven	Fai	m Rd	. Un	it"N" H	erry	Hall,	Md. 21128
Baltimore,	of Hem		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nan	ne of ther plac	e)	[Date	20c. L	ocation - City o	r Town, State
Ē	Page nent c nnt: If		1 ☐ Burial 2 🌠 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State cify)	_	vview				an.l	1,2008	Ва	1timore	. Md.
atti	permit. Departn Imports eny inju		21. Signature of Tureral Service Li	150	,		2. Name an	-			,2000		5 Bela	
m	88 = 8		I self the	4		S	chimu	nek	Funer	al H	lome,In	_		re, Md.21236
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused by one cause on each li	the deat	h. Do not en	er the mod	e of dyin	g, such as	cardiac (or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1)0	men	16							Onset and Death
4	/Medical		resulting in death)	Due to (or as	a conseq	uence of):								
	Examiner	_	Sequentially list conditions,	b	- 4.55									
	sit ad	lner	Sequentially list conditions, tary cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a cons	uence of):								
	and J-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):	_		_					
760,	te be executed ysicien and e burial-transit	calE												
687				d										
Box (certii nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of d	elivery
	death	Physician/Med	in the past 12 months? 1 □ Yes 2 ☒ No	1⊟Live birth 4⊟Pregnant a 9⊟Unknown			∃Ectopic pro ∃Other (sp						Month	Day Year
P.0	et the d by th etach	Phys	9 Unknown		_					_				
Records,	The law requires thet the death certificate be executed sie as been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	اھ	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the u	nderlying c	ause give	en in Part I	٠				to the cause of death? Probably 4 Unknown
Ö	w re-	Completed									24a. Wa	s an	24b. Were	autopsy findings available
Re	The law sete as pag 2 a	E						·			per	ormed?	death	
ta		0	25. Was case referred to medical					-	26. Place	of Deat	1 ☐ Yes h (Check only	one)	, , ,	2 2 2 140
>	Physicien: r this certifice ral director, p	ToB	examiner? 1 □ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpaties	nt 3 DO	A Oth					6 ☐Other (Sp	ecify)
0	ding Pt n. After th funeral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju	ry y Year)	28b. Time o	f 2	8c. Injun	at k?		28d. Describe	how inju	ry occurred	
Sio	Attending ir death. ector: After by the fune	atle	2 ☐ Accident investigat				М	1 🗆	Yes 2 🗆					
Division of Vital	after d Direct Jin by I	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of In building, et	ury - At he c. (Specif	ome, farm, st y)	reet, factory	, office			28f. Location City or To	(Street ai own, Stati	nd Number or i e)	Rural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Ex	Physician: To the best aminar: On the basis of and manner st	f examina	wledge, deat tion and/or in	vestigation	, in my o	pinion, dea	id place, ith occur	and due to the	, date an	d place, and d	ue to the cause(s)
)	To with	Σ	29b. Signature/and title of certifier	A 49ndin	1P	hysici	C41 290	D	number	82		Ja. Da	N, 10	1208
Ü	2		30. Name and address of person w	670(N	Cha.	(LS)	Print)	220	2 1	Bal	timo	K	102	1204
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 4	32 Règistr	ar's Signa	iture	uses							

		Please Type or Print in Bl	ack In	delible Ink.	Ensure A	I Copies	Are Leg	ible.	
		For State of Maryland				lental Hy	giene		
		Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of I	Death	O Data of D	Reg. No	AR-	20544
Physicia	an		ATTI			2. Date of De Month	Day	Year	3-71me obbeath
/Medic		IRENE RUTH MERRITT S. 4a. Facility Name (If not institution, give street and number)	MTTH_	4b. City. Town, or	Location of Death	Januar	y 11, 20	008 v of Death	5:25A M
Examin	er	LAUREL REGIONAL HOSPITAL		Laur	_				orges County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
Director		214-14-9735 1 1 N 2 X 90	Yrs.	Months Days	Tiouis Will.	May 8,	1917		yland
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				1	0d. Inside City Limits
Mary I-f sho fied a	tor	Maryland Prince Georges Co.	Lau	ro1					1 □Yes 2XNo
th the	Director	10e. Street and Number	Lau	10f. Zip Code			10g. Citizen of	What Coun	try?
23a c	la	7700 Cherry Lane, #309		2	:0707		1	USA	
tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.		
rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Speci.	fy: Wh	ite
2 hou	ed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of E	Susiness/Inc	lustry
thin 7.	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o DO NOT use retired		ing			
ygien ygien er the	Be Completed	12th	Clai	ms Analys			·		ance Comp.
be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			ne)	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ြ	George Elmer Merritt 19a. Informant's Name/Relationship (Type. Print)	10h Mailir	ng Address (Street	Emma Au			Chata Zia	Cadal
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				Willingbo					
s 1 ar if Hea item		20a. Method of Disposition 20b. Pla		sition (Name of matory or other place		Date	20c. Location		
Pages 1 nent of H int: If iter		I IM Duliai 2 Li Cielliagon 3 Li negloval lioni State I		Valley Me		/14/08	Timoni	ım Me	ryland
permit. Departn Importa any inju		21. Signald of Fund Send Libers e		Name and Address					it y taria
90 = 20		Martin D. Lawson (M00358)	6.	500 York	Road, Bal	timore	, Maryla	and 21	212
		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical	İ	Immediate Cause (Final disease or condition resulting in death) a. Respiratory 1		re					Onoce and Death
Examiner		Due to (or as a conseque		Failuro					
100 m	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dementia		larrace					
e executed lan and urial-transit	Examiner	triat iritiated events C.							
oe exe		resulting in death) Last Due to (or as a conseque	nce of):						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d							
death certificate t attending physion of the total	₩e	IF FEMALE: 23c. If yes, outcome pf pregnant	:v				224 D	ate of delive	
death atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)					Day Year
at the de by the tached	hys	9 ☐ Unknown							
res that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use con		e cause of death?
w require been sign	ted	Goiter				1 🗆	Yes 2X No	3 Prob	ably 4 ∐Unknown
The law cate has b page 2 sh	Completed					24a. Was auto	psy	prior to con	osy findings available npletion of cause of
						1□ Yes	ormed? 2XINo	death? 1 ☐ Yes	2□No
s certific	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ Ef	2/Outpation	nt 3□ DOA Othe	26. Place of Deatler:				
g Phys er this eral dir	ا ع ا	27. Manner of Death 28a. Date of Injury 2	8b. Time o		4□ Nursing Ho		how injury occu		9
endin ath. or: Aff	atio	2 Accident investigation	Injury		Yes 2 □ No				
or Att fter de pirectu n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		ber or Rural	Route Number,
pital of	Se	29a. Certifier 1 Certifying Physician; To the best of my knowl		b account at the time	an data and alam				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical	29a. Certifier (Check only one) 2☐ Medical Examiner: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	pinion, death occur	ed at the time,	date and place	anner as st , and due to	ated. the cause(s)
To the within To the Comple	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signe	ed (Month, i	Day, Year)
		1 C-ce. Callian M	9	DO	0645	39	1/11/0	30	
1	t	30. Name and address of person who completed cause of death (Item 2		Print)			1		
N		S. Kanumuru, M.D., 7300 VanDuse 31. Date filed (Month, Day, Year) 32. Registrar's Signatu		ad, Laure	ı, Maryla	ind 2070)/		
Stat Registra		JAN 1 4 2008	Los	الم مالكان					
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errin Davon Th	oma	s State of Maryland / Department of Health and Mental			0 0051
omi Davon m		-For State Criticate of Death		200	8 0054
Physicis	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	g. No. h	3. Time of Death
Physicia Iedical Examii	111/	DERRIN DAVON THOMAS	Month January 10	Day Year 0 2008	2040 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Death	
		7776 Rotherham Drive Hanover		Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birt		hplace (State or
Director	ı	2/8 - 94 - 15/84 1XM 2 F 27 Yrs. Months Days Hours	Min.	Foreign Co	untry)MARYLAND
	Ľ	Usual Residence of Decedent	MAYO	0,11001	LIVELATION
any	-	10a. State 10b. County 10c. City, Town or Location	0		10d. Inside City Limits
8	- 1	MARYLAND N/A BALTIMO	RF (17	n/	1 Yes 2 No
Maryland 28a-f show 1 at once.	윉	10e. Street and Number 10f. Zip Code		0g. Citizen of What Cou	ntry?
e le	Director	754 ENGEWHAN STREET 215	239	1151	7,
with the is 23a e noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?			ican Indian, Black,
eath ritem	uneral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.	
her d	ш	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: 3	LACK
urs a itural amin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/	Industry
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	e retired)	1	
036 ithin 72 ne. r than	Complet	12 TH GRADE OWNER		CLOTHI	NG STORE
5-0036 lled within 7 Hygiene. I other than		17. Father's Name (First, Middle, Last) 18. Mother's 1	lame (First, Middle, I abhne Den	Maiden Surname) 150 Thomas-	Smith
21215-0C buld be filed win Mental Hygier marked other ic event, the M	a	GREGORY WILLIAMS JAL	O ME	M: 1	HOMAS
D 21 hould nd Me is ma	의	19 Defprine Nath Control Strict Providence (mother) 196 1820 Wall Street and Name	or Ballon	ber 2121 Town, State	e, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. I ant; If item 27 is marked other than ' or other traumatic event, the Medical		YOLANDA LAWRENCE (PRIEND) 154 LDGEWOOD		MIHORE, HIL	
ore, ME ss 1 and 2 s of Health ar If item 27 her traums		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I at Department of He Important: If ite	Ш	4 Donation & Other Specify: KING MEM PARK O	1-17-08	WOODLA	WN, MD
Baltimo peimit. Page Department Important: injury or ot		21. June of Fineral Service See 22. Name and Address of Facility	ROWN		
© 89 = E		2140 N. FUL	TON AVE.	, BALTO, F	1021217
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	iac or respiratory ar	est, shock, or heart	Approximate Interval Between Onset and
/Medical	- 1	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
aminer	- 1	or condition resulting in death) Due to (or as a consequence of):			1
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	amine	if any, leading to immediate Due to (or as a consequence of):			
	la E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transi	EX	d			
	dical	UNPENDED **AMENDED 5 per th g8/5 1-14-08 vt *#18&19a&b Per INF C875 1/22/08 JH IF FEMALE: 23c. If yes, outcome of pregnancy			
Box 68760, a death certificate be the attending physici ed for use as the buring of the buring the buring of the buring t	ě			23d. Date of delive	ry
587 rtific ling p	au/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic page 12 months?	regnancy	Month	Day Year
ath ce	Sici	4 Pregnant at time of death 5 Other (Specify)			
he de hede f	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	23e Did t	tobacco use contribute to	the cause of death?
, P.O. Boy ires that the deat signed by the att	by	Part II. Other Significant conditions Continuum to death but not resulting in the diluenting cause given in Part		es 2 V No 3 Pro	
ords, F w requires s been sign should be	pe e				utopsy findings available
cord law req has bee	plet		auto	psy prior to	completion of cause of
Nec	Completed		1 ✓ Yes	ormed? death?	
Division of Vital Records, tal or Attending Physician: The law requir is after cleath. al Director: After this certificate has been is led in by the funeral director, page 2 should!	BeC	25. Was case referred to medical 26. Place of Death (C	heck only one)		
Vita hysich this ce	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1	Nursing Home 5	Residence 6 V Oth	er: Scene
of ng Ph After t uneral		27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work?	28d. Describe Subject wa	how injury occurred	
on tend? sath. or: /	Certification:	1 Natural 5 Pending FOUND: 1 Yes 2 ✓ N 1 Accident Investigation Jan 10, 2008 2025 hrs	o Gubject wa	3 31100	
VÌSİ or Atı fler d birect in by	ţį	2 Accident Investigation 3 Suicide 6 Could not be Could not be			Rural Route Number, City
Divital of urs affilled i	erti	4 V Homicide determined (Specify) Local Street	or Town, 7776 Rother	han Drive, Hanover, I	Md.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cau	use(s) and manner as sta	ated.
To the within 2 To the Complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occu	rred at the time, date	e and place, and due to	the cause(s)
F ≥ F 8	ξ	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		hy hi mis O.C.M.E.		January 11, 20	08
<u> </u>	1	30. Name and address of person who completed cause of death (Item 23a)			
2	5 J	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
S	tate	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature			
Regis	trar	IAN 1 4 2008			

08-00256

Do

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Lillian Thon	1-	State of Maryland / Department of Health and Mental For State Certificate of Death	Reg. No.
Physicia		gistrar Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 0921 hrs
Examir	er	Dorris L. Thomas 4b. City, Town, or Location of Dea	
	4	a. Facility Name (if not institution, give siteet and manual)	Baltimore County
		1 Fellowship Court Apartment 3 Lift Under 1 Year If Under 24H	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral	5	Social Security Number 6. Sex Months Days Hours M	in. 06/18/1935 Foreign Country) MD
Director	-	219-32-5909 1 M 2 X F 72 Yrs. Yrs.	00/19/2505
		sual Residence of Decedent 10c. City, Town or Location	10d. Inside City Limits
v any		oa. State	1 Yes 2 X No
and show	5	MD Baltimore Towson 10f. Zip Code	10g. Citizen of What Country?
Aaryl.	Director	0e. Street and Number	USA
72 hours after death with the Maryland natural", or items 23a or 28a-f show eal Examiner must be notified at once.		1 "J" Fellowship Gt. Apcs.	(Specify Yes or No- 14. Race - American Indian, Black,
ath with the items 23a ust be noti	Funeral	1. Marital Status	erto Rican, etc.) White, etc.
death or ite	اڌ	1 Never Married 2 Married 1 Yes 2 X No	Specify: White
after al", c	by F	3 Wildowed 4 22 Divorced or Dates: or Dates:	of work done 16b. Kind of Business/Industry
natur	8	during most of working life. DO NO1 use	retired)
an ",	et	Office Manager	Reality
Mental Hygiene. marked other than	ompleted	12 Office Francage 1 77. Father's Name (First, Middle, Last) 18. Mother's N.	ame (First, Middle, Maiden Surname)
uld be filed within 72 hours after Mental Hygiene marked other than "natural", c event, the Medical Examiner.	O	Marie	Hartman
d be fental	Be	Robert B. Thomas Harrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)
	2	Tracie Carraway/Daughter 904 S. Dean Street	Baltimore MD 21224
Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Battimore, permit. Pages 1 ar Department of Her Important: If ite		1 X Rurial 2 Cremation 3 Removal from State	01/11/08 Baltimore MD
Baitimo permit. Page Department (Important: injury or otl		4 Donation 5 Other Specify:	Schimunek Funeral Home Inc.
sant smit. epart npor ijury	13	21. Signature 1 eral Service 1 laser Rd.	Nottingham MD 21236
n go = :=		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	liac or respiratory arrest, shock, or heart Approximate Interv Between Onset ar
Physician		follure Liet only one cause on each line.	Death
ledical aminer		Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease	
.ammoi		or condition resulting in death) Due to (or as a consequence of):	
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	흘	cause. Enter Underlying Cause	
	Examiner	(Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of):	
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2.3 should be deached for use as the burial - transit	벁	d.	
oe exe	edical	ME,g875, 1/15/08 TT	23d. Date of delivery
760, cate be physic	Me	IF FEMALE: 23c. It yes, o come or pregnancy	pregnancy Month Day Year
Box 68766 e death certificate the attending phy ed for use as the b	Physician/M	past 12 months? 1 Live birth 2 Fetal death 3 Lessphere 4 Pregnant at time of death 5 Other (Specify)	N
ox sath c atten	Sic	1 Yes 2 No 9 Unknown 9 Unknown	the state of the s
the d	£	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknow
P.O. es that the igned by	۾		
S, I	Completed		24a. Was an autopsy 24b. Were autopsy findings avail prior to completion of cause
Ord IW Tec as be	De		performed? death?
The la	, E		Tes 2 No
Vital Rec ysician: The l his certificate	Be C	25. Was case referred to medical 26.Place of Death (0	Nursing Home 5 Residence 6 ✔ Other: Scene
Vita ysicia his ca	9	1 Ves 2 No	
Division of Vital Records, tale or Attending Physician: The law requin rs after death. The third of After this certificate has been so it is a constant of the constant of th			No
on endir ath.	į	1 V Natural 5 Pending Investigation Investigation	The state of the s
r Att rer de irect	ان ا	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be	or Town, State)
Cital of Ital	Cartification.	4 Homicide determined (Specify)	
Division of Vital Records, P.O. Box 68/66 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician of the funeral formers and a 2 should be denothed for use as the behavior to the funeral formers and a 2 should be denothed for use as the behavior and the behav			ce, and due to the cause(s) and manner as stated.
the I	Modical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the time, date of the time, d	29d. Date signed (Month, Day, Year)
To To	3 5	29c. License number	29d. Date signed (Month, Day, real)
		O.C.M.E.	January 10, 2008
		30. Name and audiess of person who completed cause of death (Item 23a)	
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 21201
	1		
Rec	Sta	A A THE STATE OF A STATE OF THE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Marv Ward 2008 January 11:59a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M Hours 212-36-3117 Director April 4 1913 England Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at MD Carrol1 Sykesville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Martz Road 21784 USA Funeral **items** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Specify: ģ white 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker the domestic 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Howard Kate Booten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glynis Dill (daughter) 25 Martz Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 1-15-08 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ▶ Page Haight) erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy 1[25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1, Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 A ROAD WESTMINSTAR 151.HAM MACANIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2008

00548 State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Physician GRACE M. WUNDER G: OD PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MD 21223 BALTIMONE N/A BON SECOUL HOJPITAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 03/24/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2K□ F Yrs 212-01-4499 88 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD N/A Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 South Tremont Road 21229 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary other permit. Pages 1 and 2 should be fite Department of Health and Mental Hy, important: If item 27 is marked othe eny injury or other traumatic event, gings. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Neubauer Louis Dorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12075 Susan Lane, Lusby, Maryland 20657 Angela Burgess (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MD Veterans-Garrison 01/16/2008 Owings Mills, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 MartiT-23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** NEW MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ HUPERTENSION , CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed DEHUDRATION; HUPOTHYROID 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? RENAL INSUFFICIENCY: ATMAL FIBRILLATION 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation Natural 1 Yes 2 No death. 2 Accident the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number mophibely, mo Diejed cause of death (Item 23a) (Type, Print) TOND W. BALTIMINE BALTIAWNE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #29d Per Phy G875 1/14/08 The Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** EROY WALKER 08 (o /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6839 Eastbrook Avenue N/A Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours 217-12-6100 83 Yrs. Director May 2, 1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at TY∑Yes 2 ☐ No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Directo Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6839 Eastbrook Avenue 23a 21224 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Items 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White þ Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 years General Foreman Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey E. Walker Elsie J. Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Walker wife 21224 6839 Eastbrook Avenue, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ¶∏ Burial 2 □Cremation 3 □Removal from State January St. Stanislaus Cem. Baltimore, Maryland 4 Donation 5 Dother (Specify) 10, 2008 Signature of Fyneral Service Licenses Chinelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jeteremi /Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (on as a consequence of) Examiner The law requires that the death certificate be executed =V the burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical SB attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 200 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed?

1 Yes 2 No. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home ospital or Attending Physic hours after death.

Ineral Director: After this ce illed in by the funeral direal direal. 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Feath 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date spigned (Month, Day, Year) 1/07/2008 =U وس 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 LO 3509

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Year)

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2008

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Weaver **Physician** 3:55 PM Th 2008 Januar /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore 5. Social Security Number Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 212-32-3836A Usual Residence of Decedent 1 M 2 F Director 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 nes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Bush Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 P No 1 New Married 2 Married Specify: Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lowekeepin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NICE four 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Leculard 20b. Place of Disposition (Name of cemetery, crematory or other property) 20a. Method of Disposition 1 Burial 2 Termation 3 ☐Removal from State 15 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the diseas shock, or heart failure. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final ive Heart est **Physician** disease or condition resulting in death) /Medical Examiner DAYS neumoni Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DAYS USIO Due to (or as a consequence of) Affer this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial-Box 68760 rointestinal bleed Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records. 2 No 3 Probably Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform a□No 1 Yes 1□ Yes 2□ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No No 1 Inpatient 2 2 ER/Outpatient 3□ DOA After this Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. To the Hospital or Attenct within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Caton avenue.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 unuan Bernard W. Warthen /Medical 4c Jounty of Death adlity Name (If not institution, give street and number) City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, Social Security Number **Funeral** Hours Year. i M 2□F Months Jan. 1945 Director 216-40-0729 1, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 1 ☐ Yes 2X No items 23a or 28a-f sh ner must be notified Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 197 Newburg Avenue Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 ☐ Never Married 2 X Married 9 Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Business Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumattic event once. Florence Mildred Nelker Francis X.Warthen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 197 Newburg Avenue; Catonsville, MD 21228 Wife Mary Jo Warthen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 1/14/08 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fundal Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 minutes ALUKE Myplandial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Diabetes 1 Yes 2 No 3 Probably 4 Hhknown Completed Vasiular disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hypercholeski ofemin 1 | Yes medical 26. Place of Death (Check only one) 25. Was case referred to Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD DEA 319916795 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Ballimore

	-	For State Registrar	Sta	ate of N	//arylan	•	artment d tificate		th and Mo ath	-	giene Reg. No. 0	08	00552
Physicia	n	1. Decedent's Name (First, Mic	idle, Last)			1//	'GG1	1/5		2. Date of De Month	Day	Year	3. Time of Death 2/55 PM
/Medica	al	4a. Facility Name (If not institut	ion, give street	and numbe	or)	707			ition of Death	0/		2008 ity of Death	2/337
i ger		WASHINGTON						KON		+RIL			OMERY
Funeral Director		5. Social Security Number 579 42 5601	6. Sex 1 ☐ M 2		Age (In yrs. 1 93	ast birthday) Yrs.	If Under 1 Y Months D		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da NOV • 26	v. Year)	Cour	place (State or Foreign http:/ HINGTON, DC
		Usual Residence of Decedent 10a. State 10b. Cour	ntv			y, Town or Lo	cation						Od. Inside City Limits
Maryla	ō		CE GEOR	GES		PER MAI							XX Yes 2□No
or 288	Direc	10e. Street and Number					10f. Zip Co				10g. Citizen o		
ns 23a	Funeral Director	11908 BERRYBR	12. W	as Deceder	nt Ever in U.	S. 13. V	Was Decedent	20772 of Hispani	ic Origin? (Spe	cify Yes or No		TED S.	
S as of all	2	1 Never Married 2 M	arned 1 [med Force: Yes 20 Yes, Give ear or Dates	s? X No		fYes, specify I⊡Yes XIX	Cuban, Me	exican, Puèrto F ecity:	Rican, etc.)	В	lack, White,	
n 72 h	letec	(Specify only high	1 -			(Give	lent's Usual O kind of work of DO NOT use n	one durina	most of workir	1g	16b. Kind of	Business/In	dustry
d withii giene.	Completed	Elementary/Secondary (0-12 8TH	() Co	ollege (1-4o	or 5+))	CARE		IDER		PRI	VATE	
is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	Be	17. Father's Name (First, Midd. JAMES SCOTT	le, Last)						Mother's Name	(First, Middle,	Maiden Sum	ame)	
should nd Mer marke umatic	၉	19a. Informant's Name/Relation	nship (Type, Pi	rint)		19b. Mailin	g Address (Si		lumber or Rura	l Route Numb	er, City or Tow	m, State, Zip	Code)
and 2 and 2 saith a n 27 is		DIANA D. WIGG	INS / D	AUGHT			BERRYE				MARLBO		
Pages 1 Dent of H nnt: If ite		20a. Method of Disposition XX Burial 2 □ Crematio		al from Stat	te	emetery, cren	sition (Name on natory or other	place)	1	ate	20c. Locatio		
permit. Pages 1 Department of H Important: If ite eny Injury or ott		4 Donation 5 Other 21. Signature of Funeral Service			CED	22 M.	L CEME Name and A ARSHALL	ddress of F	01/18 Facility UNERAL	HOME OI	MARYL	AND,	INC.
1010 d		23a. Par1. Enter the disease,	or complication	s that caus	ed the death		808 SUI or the mode of				LAND, M	D 20/4	Approximate
Physician		shock, or heart failure. L Immediate Cause (Final disease or condition				LERO	2776.	CAR	DIOVA	BLULA	L DI	SEASE	Interval Between Onset and Death
/Medical Examiner		resulting in death)			as a consequ								
ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹ "-	Due to (or a	as a consequ	uence of):							
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to (or a	as a consequ	uence of):							
cate be exphysician the buria	dical		d										
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that the death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1[☐Live birth	2 Fetal	death 3	Ectopic pregr Other (specif					Month	Day Year
s e igne	<u>a</u>	Part II. Other significant cond	itions contribut	ing to death	but not resi	ulting in the ur	ndertying caus	e given in F	Part I.		obacco use co Yes 2 ☐ No		he cause of death?
The law re cate has be page 2 sho	Completed									24a. Was auto perio 1 Yes		o. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
sician: Th certificate rector, pag	Be	25. Was case referred to medi examiner?	cat Hospita	al:				Other	Place of Death				
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tendin leath. tor: Aft the fun	catio	E LI Modidorit	stigation			Injury	М	1 Yes					
el or At elter o l Direct d in by	Certification:		mined 286	e. Place of I building,	Injury - At ho etc. (Specif)	ome, farm, str V)	eet, factory, of	fice	2	28f. Location (City or To		mber or Rur	al Route Number,
	edical	29a. Certifier 1 Certifier (Check only one) 1 Medic	ying Physicien al Examiner: O	: To the be in the basis nd manner	of examina	wledge, death tion and/or inv	occurred at to vestigation, in	ne time, da ny opinion	ate and place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
withii To the comp	Ž	29b. Signature and title of certi	HOL				29c. Li	cense num	nber		29d. Date sig	ned (Month,	Day, Year)
, ~	-	30 Name and address of person	on who comple	up ed cause o	f death /lto~	23a) (Tuno	Print)		0031	9	01	, 10	,2007
1		DARCIE	HAN	MO	1	7	501 CAI	RROLL	AVENUE	TA	KOMA PA	ARK, M	D 20910
Stat Registra		31. Date filed (Month, Day, Ye JAN 1		32 Regis	strar's Signa	ture	Met 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend 16a, perFH, 26, perMD, 6875, 1/14/08 TT Certificate of Death

Registrar

Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JAN.9,2008 ARTHUR E.WOODLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 ☐ F OCT.11,1948 MD. 59 Director 218 48 4692 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 ☐ No BALTIMORE N/A Director MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA 2218 E.NORTH AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1-15-68_{1□Yes} 2√2No 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 2 3 Widowed 4 Divorced 1 - 14 - 71Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE UNEMPLOYMENT Elementary/Secondary (0-12) College (1-4or 5+) OFFICE llth ALIEN RIGHTS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARTHUR E. WOODLEY GERTRUDE SMITH ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GERTRUDE COLLINS (mother) 2218 E. NORTH AVE. BALTO, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot GARRISON FOREST VETERAN CEM. 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGSMILLS, MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME ature of Funeral Service License PRESTON ST. BALTO, MD. 21213 1412 E Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Obohuctra Immediate Cause (Final disease or condition Chrone Dise **Physician** resulting in death) /Medical Examiner novocale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical 23c. If ves, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9□Unknown 9 Unknown مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed2 1□ Yes 2□ No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) P this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Certification: Division (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After within 24 hours a

To the Funeral I

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHV AIR A - HAShmir & 21 N EUTHVST Fru 30 F Bit CIRVING 32. Registrar's Signature 31. Date filed (Month, Day, Year)

MD

29c. License number

D 31444

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygienolimits 0 0 81 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ommy January 8, Lewis 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 1209 B Little Brook Drive Frederick
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Frederick 5. Social Security Number 3. Date of Birth (Month, Day, Year) 04/04/1959 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Yrs. Director 48 220-74-9234 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Marvland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1209 B. Little Brook Drive 21702 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 welder welding company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Gordon Palmer Alston <u>Ella Louise Jackson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Louise Alston/ mother 8323 Darkwood Ct., Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 01/09/2008 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford PA Funeral home 21. Signature of Funeral Service Licensee MO1222 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician angina /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation with rope 50/1 death. ecomper 2001 unknown M 1 ☐ Yes 2 No ours after death.

neral Director: A
filled in by the fu 2 Accident 28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify).

28f. Location (Street and Number or Rural Route Number,
City of Town, State).

28f. Location (Street and Number or Rural Route Number,
City of Town, State).

28f. Location (Street and Number or Rural Route Number,
City of Town, State).

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City of Town, State).

28f. Location (Street and Number).

28f. Location (Street and Numbe 3 Suicide 4 ☐ Homicide 6 Could not be within 24 hours a To the Funeral L 29a. Certifier Medicai he 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Same and addr-ss of person who impleted cause of death (Item 23a) (Type, Print) Street Freferick MD 21701 lan Kobrer 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0241 AM Helga Black TANUARY 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown Year I If Under 24 Hrs. If Under 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 XF 63 May 4,1944 Director 214-42-2132 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r 28a-f show notified at 1 Yes 2 XNo Washington Williamsport Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be a 21795 U.S.A5 H Oak Tree Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify. ρ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) If item 27 is marked other than ", ir other traumatic event. the Man." Elementary/Secondary (0-12) College (1-4or 5+) Beautician Salon 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hildegard Plotzitzka ဥ George A. Fitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 H Oak Tree Lane Williamsport, Md. 21795 Hildegard Fitz (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any Injury or ot Jan. 5. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4 Donation 5 Dother (Specify) 2008 Smithsburg, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 art1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Vear 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy this certificate har death≀ 1 ∐ Yes 2 No 2 4 No 1□ Yes 25. Was case referred to medica 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Hipatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 3□ DQA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Beatl 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 A Natural

Division or Vital Records, P.O. Box 68760, or Attending Physician: After within 24 hours after death.

To the Funeral Director: All completely filled in by the fu To the Hospital

7

DHMH 17 Rev 1/2001

Registrar

State

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

ANTIETOM

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

			1 - For State Ageistrar State Of Maryland / Department of Health a Certificate of Death		, ,	jiene g. No. 2	0.08	0.055	5 [
	Discours :		Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day	Vone	3. Time of Death	1
	Physici /Medio		Herbert Campbell	į	January	6, 20	008 Year	1328	М
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. Cou	nty of Death		
_			Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	ice		На	rford		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 232–46–0891 1XM 2 F 77 Yrs. Months Days Hours	Min.	8. Date of Birth Month Day 8 / 21 / 19:	(ear)	9. Birthp	olace (State or Fore otry) Virginia	vign
	Director		Usual Residence of Decedent	F	0/21/19.	30	West	virginia	
	lanyiand show		10a. State 10b. County 10c. City, Town or Location		···		1	0d. Inside City Lim	iits
	the Mar 28a-f sh	tor	MD Cecil North East					1 ☐ Yes 2 🔯	No
	th with the Maryis 23a or 28a-f shoust be notified at	Jire	10e. Street and Number 10f. Zip Code		1	0g. Citizen	of What Coun	ntry?	
	ath w	la I	170 Northwoods Blvd. 21901			U.S.	A.		
	ter dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	rigin? (Spe .n, Puerto f	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	irs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	:		Spe	ocity: Whi	to	
2 <i>§</i> 5-0036	filed within 72 hours after death with the Maryland Hygiene. Ither then "naturel", or Items 23s or 28s-f show int, the Medical Examir or must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of	f Business/Inc		
215	hin 7.	pie	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	st of working	ng			,	
77	filed wi Hygien Ither th	Completed	9 Mechanic			Conc	rete C	0.	
pu	S is b	Be	17. Father's Name (First, Middle, Last) 18. Mothe	er's Name	(First, Middle, i	Maiden Surr	name)		
, ryland	d Mer narke	P_		lda E					
∑ a	s 1 and 2 should f Health and Mer fem 27 le marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Herbert K. Campbell (Son) 19b. Mailing Address (Street and Number 170 Northwoods Blvc)						
, O	s 1 and 3 f Health item 27 other tr	1	20a. Method of Disposition 20b. Place of Disposition (Name of		North Ea		D 219 on - City or To		
200	80=5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Raker Compters	1/0/0			•		
0	permit. Par Departmen Importent: any Injury once.		4 □ Donation 5 □ Other (Specify) Baker Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1/9/0	Jö F	berde	en, "a	ryland	
B	Depariment Deparement Important In postering P		Kursen Hnylingusber Aberdeen, Mary	Funer	ral Home	3300A	•		
0			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or	r respiratory arr	est,		Approximate Interval Between	
	Physician		tmmediate Cause (Final disease or condition a. Commany externs E	2150	ease			Onset and Death	
	/Medical		resulting in death) Due to (or as a consequence of):						_
工	Examiner		Sequentially list conditions, b. Rectal Cancer						
4) -	[] []	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that be independent of the conditions)						
9	xecut and al-trar	xan	that initiated events resulting in death) Last c. C. C. Due to (or as a consequence of):						
PE 1	ate be executed the burial-transit	calE							
上89	ifficati g phy as the								
- X	death certifica e attending pt ed for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the control of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. I	Date of delive	nry	
3.	ne deat the att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			1	Month	Day Year	
J. 9.	et the	Phy	9 Ouknown		1				_
3	Attending Physician: The law requires thet the death certific ir death. If death. ector: After this certificete has been signed by the attending py the funeral director, page 2 should be detached for use as by the funeral director.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	I.		1./		e cause of death?	
Z oic	v requ	Completed			1 🗆 Ye	s 2 MNo	3 Prop	ably 4 Unknow	w n ——
360	2 8 8	mp			24a. Was a autops perform	V	b. Were autor prior to con death?	psy findings availal apletion of cause of	ole I
	ician: The lav certificete has rector, page 2		25 Was and referred 5 modical		1 ☐ Yes 2	2 Va No	1 Yes	2□ No	
\mathcal{CHW} Division of Vital Record	s certi	To Be	Hospital:		Check only on		24 (2 /		-
ō	g Phys er this eral dii		27. Wagner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ne 5 Reside			')	
io	ttending F death. stor: After	atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 N	No					
ivis	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (St City or Town	reet and Nu	mber or Rura	l Route Number,	
Q	itel or irs efte rel Diri	Ce							
	To the Hospitel or Attending Physician: The within 24 hours elter death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death	id place, a ath occurre	and due to the ea	iuse(s) and ate and plac	namel as st	ated. the cause(s)	
	o the ithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number				ned (Month, I		
	To Will		D20/6		2	1/	(C	-wy, rear/	
	1	1	30. Name and address of person who want leted cause of de th (Item 23a) (Type, Print)	· ·		19	05		
a x-	\	-	JTLEEMP. 669 Revolution St. Hours	do	Grace	N	102	1078	į.
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				V		
	Registra	ar	TAN 1 1 2008 100000 000						

		4	For _ State	State of Mary		artment of H <i>rtificate of L</i>			/	008	00558
_			Registrar	(and)	Ce	rinicale of L	Jeani –	2. Date of Deat	eg. No.— h	000	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle,		11			Month	Day	Year	8:20 A M
	/Medic	-	Frances Murray 4a. Facility Name (If not institution,	THE PROPERTY OF THE PARTY OF TH	laytor	4b. City. Town, or	Location of Death	January		unty of Death	
	Examin	er	Maplewood Park_			Bethes	da		Mo	ntgome	rv
lais us	Funeral			6. Sex 7. Age (II	n yrs. last birthday,	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birth	place (State or Foreign intry)
	Director		578-62-1753	1□M 20€7 F 9	92 Yrs.	Months Days		Sept.2,1			rginia
3			Usual Residence of Decedent	140	oc. City, Town or L	ocation		•			10d. Inside City Limits
2	show	-	10a. State 10b. County								1 GyYes 2 □ No
M Co	8a-f	ecto		tgomery	Bethesd	a 10f. Zip Code		1	On Citizer	n of What Cou	intry?
4	a or 2	Funeral Director	10e. Street and Number				,	,			····,
4	is 23a	eral	9707 Old George	town Road 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi		ecify Yes or No-		S.A. Race - Amer	ican Indian,
- 0	Item	'n.	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		Black, White	e, etc.
2 2	xami	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:		S	pecify: Wh	ite
3-000c	atura	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	edent's Usual Occup	ation		16b. Kind	of Business/I	ndustry
7	e. Med	ple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done o DO NOT use retired)	9			
, ;	/gien /gien t, the	8		5+	Ow	n Home	40.14.1	(F) 1 3 4'-1-H-		e Make	r
	a oth	Be (17. Father's Name (First, Middle, L	ast)			18. Mother's Nam			irname)	
<u> </u>	Men arke	၉	Edward Murray		T		May Moir			C4-4- 7	En Cada)
Na.	ls m		19a. Informant's Name/Relationsh			ing Address (Street					
ב ט	lealth Jem 27 Jen 1		Frances M.MacDo		20b. Place of Disc	osition (Name of	arrett Pa			tion - City or	
2	iges if ite or or		1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cir	ematory or other plac	Janu	ary 9,	Daan	. 1	irginia
baltimor	rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Fun ral Service I			iew Cemete 22. Name and Addre		8 Vol Fune			IIginia
מ	perfill. Tages I ain 2 should be fine whithin 72 hours are negative min for waryand the propertient of Health and Mental Hyglene. Inportant; If I tem 27 is marked other than "natural", or hems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of partial service i			2222 Wisco	DE				20007
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the							Approximate Interval Between
			shock, or heart failure. List of Immediate Cause (Final								Onset and Death
F	hysician /Medical		disease or condition resulting in death)	a. Myocaro	dial Infa	rction				-	
≥ €	Examiner				ry Artery	Disease					
L		ě	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or es e o							
	oured Ind	Examiner	Cause (Disease or injury that initiated events	C							
Ď.	e exe	Ë	resulting in death) Last	Due to (or as a c	consequence of):						
04/8	I he law requires that the death certilicate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical		d							
õ	ing ph	a I	IF FEMALE:						T.		
POX	attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1□Live birth 2	Fetal death 3	□Ectopic pregnancy	y		23	d. Date of del Month	livery Day Year
5	the at	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5	Other (specify) _					
л Э	uires that the de signed by the a Id be detached f	Ph	Part II. Other significant conditio	ns contributing to death but r	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use	e contribute to	the cause of death?
Vital Records,	signe signe	Completed by	Hypertension	· ·				1 🗆 Y	′es 2[<u>X</u>	No 3∏Pr	robably 4 Unknown
Ö	w require been si should b	etec						24a. Was a	an	24h Were au	utopsy findings available
ě	has has	ם	Congestive He					autop perfo	rmed?	prior to death?	completion of cause of
a	sician: The law certificate has t irector, page 2 s		Severe Kyphos 25. Was case referred to medical	is			Of Place of Doc	1 Yes ath (Check only o	1	1 □ Yes	2 □ No
5	sicia certi recto	Be c	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 □ ER/Outpati	ent 3 DOA Oth	er.	tome 5 ☐ Resid		□Other (Spe	ocify)
Ö	Phy erthis erald	1. To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju		28d. Describe h			
DIVISION OF	th. :: Afte	tio	1X Natural 5 ☐ Pending 2 ☐ Accident investig		<i>Year)</i> Injury		Yes 2 □ No				
<u> S</u>	Atter r deal ector by the	fica	3 Suicide 6 Could n 4 Homicide determi		/ - At home, farm, s	street, factory, office	10.22	28f. Location (S City or Tow	Street and	Number or R	ural Route Number,
5	al or al Dire	Certification:	4 🗆 Holliicide	building, etc.	(Opecity)				,,, 0.0.0,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the best of Examiner: On the basis of e	my knowledge, de	ath occurred at the ti	me, date and place	e, and due to the urred at the time.	cause(s) a	and manner as place, and due	s stated. e to the cause(s)
	in 24 he Fi plete	edical	one)	and manner state	ed.						
	Vithi To t	Ž	29b. Signature and title of certifier	110		29c. Licens					th, Day, Year)
	- 1			· Venu	/		5791		Ja	nuary	4, 2008
	no		30. Name and address of person	who completed cause of deta	(Item 23a) (Typ	e, Print)	27 041	r Snrine	ма	20902	
	J		Merlyn Vemury,	M.D. 9801 Geo	orgia Ave	suite 2	7/ SITAG	r shrring	,riu .	20302	
	Sta	ate	31. Date filed (Month, Day, Year) JAN 1 4 2			AR B					
	Regist			THE RESIDENCE A	65 STATE AND STATE OF THE STATE	NOTES 27 -					

00559

For State Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	,	Cei	tificate of	Death		Reg. No.			
	Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ath	3. Time of Death		
hysician	BILLY DA	LE DALTON				Month January	Day Year 5 2008	7:40 P ^M		
/Medical	4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	r Location of Deatl		4c. County of Deat			
	3463 Wilson Ro	ad		Stre	et		Harfo	ord		
neral	5. Social Security Number		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. Birt	hplace (State or Foreig		
ector	215-58-2564	XXM 2□F	55 Yrs.	North Bays	Tiodis Iviai.	6/14/1		ginia		
> 15	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	parting						
Important: If item 27 is marked other then "natural; or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	MD Harf		Street					10d. Inside City Limit 1 ☐ Yes 2 🗓 N		
octo		J. C.	20166							
be notified Director	10e. Street and Number	-		10f. Zip Code				g. Citizen of What Country?		
ra le	3463 Wilson R			21154			USA			
iner must Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	Black, Whit	14. Race - American Indian, Black, White, etc.		
by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🛣 Divorced	II Van Ciua A		1 ☐ Yes 2 📉 No Specify:			Specify: White			
a pa	15. Deceden		16a Decer	dent's Usual Occup	ation		16b. Kind of Business/	Industry		
nt, the Medical i	(Specify only higher	st grade completed)	(Give	kind of work done DO NOT use retired	during most of wor	rking		,		
T E	Elementary/Secondary (0-12)	College (1-4or 5+)	Self-	-Employed			Auto Body F	Repair		
Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sumame)			
atc ev	Bill F. Da	lton			Shir	ley M. S	pangler			
T L	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ural Route Numbe	ar, City or Town, State, a	Zip Code)		
ž.	Shirley M. Dalte	on/Mother	3463	Wilson R	oad, Str	eet, MD	21154			
othe	20a. Method of Disposition	1	20b. Place of Dispo	sition (Name of matory or other plac	re)	Date	20c. Location - City or	Town, State		
ry or	1 Burial 2 XCremation 4 Donation 5 Other (S	3 □Removal from State pecify)	Evans Eac			/2008	Leola, PA			
in e	21. Signature of Funeral Service			2. Name and Addre		, 2000	20024, 111			
any ic	(Jelleurt	i meled	Ha	irkins Fu	neral Ho	me, Inc.	, Delta, PA	17314		
	23 . Party Enter the Asease, or	complications that caused the only one cause on each line.	eath. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between		
cian	Ummediate Cause (Final		static	1	_			Onset and Death		
dical	disease or condition resulting in death)	a. Due to (or as a co		caning	Cano			3 month		
iner				_						
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a co	msequence of).							
ial-transit	that initiated events	c. ========								
Exa	resulting in death) Last	Due to (or as a co	onsequence of):							
as the burial-transit		d.								
	IF FEMALE:	7								
for use	23b. Was decedent pregnant	23c. If yes, outcome of p	oregnancy Fetal death 3	Ectopic pregnancy	1		23d. Date of de Month			
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim 9☐Unknown	e of death 5□	Other (specify)			Month	Day Year		
be detached by Physic	9 🗆 Unknown							41.40		
be d	Part II. Other significant condition	ons contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		obacco use contribute to			
should						12	res 2 □ No 3 □ Pi	robably 4 Unknow		
2 sh						24a. Was	osy prior to	utopsy findings availab		
page 2 s						perfo 1 ☐ Yes	rmed? death?	2 No		
ral director, pag	25. Was case referred to medica examiner?		11 11 11 11		26. Place of De	ath (Check only o	one)			
To E	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursing H	lome 5 Resid	dence 6 Other (Spe	cify)		
neral	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	f 28c. Injur Wor	y at k?	28d. Describe I	now injury occurred			
by the funera	2 Accident investi	gation	, , ,		Yes 2 ☐ No					
t le p	3 Suicide 6 Could 4 Homicide determ			eet, factory, office		28f. Location (S City or Tox	Street and Number or R. vn, State)	ural Route Number,		
led in by the funera Certification:										
completely filled in by the fu		ng Physician: To the best of m Examiner: On the basis of ex- and manner stated	amination and/or in							
Сошр	29b. Signature and title of certifig			29c. Licens	se number	,	29d. Date signed (Moni	th, Day, Year)		
	-	n		25	5484/		1/7/0	8		
5	30. Name and a ess of person	who completed cause of deatl	n (Item 23a) (Type,	Print)			6			
2	Philip Nivatr	umin, M.D., 60	2 S. Atw	ood Road,	Suite 2	00, Bel	Air, MD 210	014		
State	31. Date filed (Month, Day, Year)	32. Hegistrar's	Signature							
gistrar	JAN 1 4 2	908 Acres	H Down							
Rev 1/2001	Will I I		7							

			1 - For State Registrar		State o	f Maryla		irtment o <i>tificate d</i>			Mental Hy	giene Reg. No.		00560	
Ý,	Dhunia		1. Decedent's Name (First	, Middle, Las	1)						2. Date of De Month	ath Day	/ Year	3. Time of Death	
	Physic /Medi		MARK JAMES DORSEY								January		3:55 A ^M		
	Exami		4a. Facility Name (If not in	-		mber)		4b. City, Tow			n	1	County of Dea		
,	· Aug	4	Rosewood Center Owings Mills								Baltimo:				
N.	Funeral Director		5. Social Security Number 215–94–6140	10	x 1 2 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yo Months Da		ider 24 Hrs. Irs Min.	8. Date of Bir (Month, Da 4/24/]	th ly, Year) .962		thplace (State or Foreign ountry) Aryland	
	and and		Usual Residence of Decederation 10a. State 10b.	County		10c. C	City, Town or Lo	cation						10d. Inside City Limits	
	Mary f sho	0	MD Ba	ltimor	e		-	Mills						1 ☐ Yes XZ O XNo	
	the 28a	Pec	10e. Street and Number					10f. Zip Coo	le			10a. Citi	izen of What Co	ountry?	
	3E ol	Funeral Director	200 Rosewoo	d Lane					21117			3	USA		
	death	ner	11. Marital Status		12. Was Dece Armed Fo	edent Ever in	U.S. 13. V			Origin? (S	pecify Yes or No o Rican, etc.)	-	14. Race - Ame		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23c or 28a-f show other traumatic event, the Mudical Examinst must be notified at	þ	1 Never Married 2 3 ☐ Widowed 4 ☐ D		1 Tyes If Yes, Giv Year or D	2 □X No ⁄e		Yes, specify (o Rican, etc.)		Black, Whit	e, etc. White	
2-0	72 ho	sted	15. D	ecedent's Edu	ucation le completed)		16a. Deced	ent's Usual Ockind of work do	cupation	most of wo	tina	16b. Ki	nd of Business	Industry	
121	iene.	Completed	Elementary/Secondary		College (1	-4or 5+)	life. E	cupati	tired)	nost or wor	KIIIG				
b	filed Hygie other	Be C	17. Father's Name (First, I	Middle, Last)					18. M	other's Nan	ne (First, Middle,	Maiden	Sumame)		
Maryland	should be and Mental a marked o	ToB	William A.	Dorse	У					Lil.	lian Phi	11ip)S		
ary	2 short and halfs ma		19a. Informant's Name/Re				19b. Mailin	g Address (Str	eet and Nu	mber or Ru	ral Route Numbe	er, City o	r Town, State, 2	Zip Code)	
Σ,	and and in 27		Pat Sturdiv	ant/Si	ster		-			ry Ro	ad, Stre	et,	MD 211	L54	
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 Burial 2 Cren		Removal from		Place of Dispos cemetery, crem	sition (Name of atory or other	place)		Date	20c. Lo	cation - City or	Town, State	
Ę,	tmen tent: tent:		`4 □Donation 5 □O	ther (Specify)		Eva	ans Eagl				2008	Lec	ola, PA		
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra		21. Signatur of Funeral S	service Licens	- In	ules		Name and Ad rkins			me, Inc.	, De	elta, PA	17314	
			3a. Part1. Enter the dise	e. List only o	ications that c	aused the dea	Do not ente	r the mode of	dying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between	
E	Pnysician	1	mmediate Cause (Final disease or condition		9	eneral	12ed	sesi						Onset and Death	
	/Medical Examiner				resulting in death) Due 1 (or as a consequence of): Introductions Due 2 (or as a consequence of):							1.6			
		ner	Sequentially list conditions if any, leading to immedial cause. Enter Underlying Cause (Disease or injury	i.	Due to (or as a consequence of):									weeks	
Ng.	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	o. Duate	or as a cons	GUMISM	Int	ection	1				weeks	
68760,	ificate be executed g physician and as the burial-transit				1 0 0 0 0	or as a cons	iquence on).								
89	tificat ng phy as th	fedicai	<u> </u>												
Вох	eath certi attending i for use a	an/N	IF FEMALE: 23b. Was decedent pregn	anı	3c. If yes, out	come of pregr		Ectopic pregna	ncv			2	23d. Date of del	,	
.O.	at the death by the atte	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	6.7		ant at time of		Other (specify					Month	Day Year	
۵.	es that the igned by be detact		Part II. Other significant c	onditions cor	ntributing to de	ath but not re	sulting in the un	derlying cause	given in Pa	art I	23a. Did to	ohacco u	se contribute to	the cause of death?	
Records,	The law requires that the death cert tee has been signed by the attending age 2 should be detached for use a	ted by									1 🗆 Y			obably 4 Dunknown	
Sec.	e law i has be	Completed									24a. Was autop	sy	prior to	topsy findings available completion of cause of	
											perfo		death? 1 ☐ Yes	2 No	
Viital	Dec Cel	Be	25. Was case referred to n examiner?		lospital:				Othor		th Check onli o		/	1000	
of		n: To	1 Yes 2 No 27. Manner of Death		28a. Date o		28b. Time of Injury	28c. Ir	njury at Vork?	Nursing H	ome 5 Resid		occurred	city) ICTMR	
Sio.	Attendir death. ctor: Af y the fur	atio	2 Accident	Pending investigation	(1000)	n Day Toury	madry		Yes 2	□No					
Division	tal or Attendi s after death. al Director: A ad in by the fu	Certification:		Could not be determined	28e. Place buildin	of Injury - At I	nome, farm, stre ify)	et, factory, office	09		28f. Location (S City or Tox			ıral Route Number,	
	1 1 1	edicai C	29a. Certifier 1 Co	ertifying Phys adical Exami	sician: To the ner: On the ba and mann	sis of examin	owledge, death ation and/or inve	occurred at the estigation, in m	time, date y opinion, d	and place, death occur	and due to the orred at the time, or	cause(s) date and	and manner as place, and due	stated, to the cause(s)	
	To the Hos within 24 ho To the Func	Med	29b. Signature and title of	certifier	and maill	- Cidiod.		29c. Lice	ense numbe	er		29d. Date	e signed (Montl	h, Day, Year)	
) '	- > 0		▶ Clay I	+ tin	11201 11	MA FAY	P		02	2500		1-	4-08		
	3		30. Name and address of p	erson who co	O M I .	of death (Ite	m 23a) (Type, P	rint)			NIN65 N	1111	C MA)1117	
563	⊚ Sta	te	31. Date filed (Month, Day,	Year)	ASP. Re	egistrar's Sign		SCWOU	y L/	V 01	WINGS N	1(4)	1 110 2		
	Registr		TANT	7 mm		-8	Brook	20							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marybell Castle Everhart January 2008 12:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Northampton Manor Frederick 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 21, 1 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 251-30-3269 1 M 2 X F 1914 93 Director Usual Residence of Decedent la or 28a-f show t be notified at 10h. Count 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Frederick Director Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street, Room 123 21701 United States ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 73 in and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Fashion Interior Decorator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Bell Hinea Otto Beall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~2170219a. Informant's Name/Relationship (Type. Print) Nena Eyler / Friend 201 Thomas Johnson Drive, Suite 101, Frederick, MD item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot January 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 8, 2008 4 ☐ Donation 5 ☐ Other (Specify) Reeney & Basford P.A. Funeral Home 106 <u>Fast Church Street, Frederick,</u> MD 21701 21. Signature of Funeral Service Licensee M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STIVE IM ONT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 10 FON CUTY Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed 为,09289 xog that initiated events and burial-trai resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has performe 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Tes this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred al or Attending F after death. I Director; After d in by the funera Certification: Division 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Hospital 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09689 Gra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin A. Pearre M.D. 300 West Ninth Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JAN 1 4 2008 Registra

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

George

Albert

Fitz

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5 H Oak Tree Lane Williamsport Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 € M 2 □ F 79 219-20-1198 Director Feb. 22, 1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Maryland Washington Williamsport 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 5 H Oak Tree Lane 21795 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. WWII 1 Tyes 2 No WW If Yes, Give Year or Dates: 41-47 1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megones. Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Board Of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel E. Fitz ပ Elsie M. Fissell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hildegard Fitz (Wife) 5 H Oak Tree Lane Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Januar Smithsburg Crematory 2008 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physicián /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the n signed by th 1 be तन् 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco-use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 입 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) de. LASCIII (1111) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registra DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

January 7, 2008 ear

1:35 A. M

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760,

signed by the a director,

certificate

Funeral D 24 hours

To the

To the Hospital or Attending Physician:

\$

Completed

Be

မ

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? I ☐ Yes 2 ☐ No 9 Unknown

If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Approximate Interval Between Onset and Death

4:30 P

10d. Inside City Limits

1 Yes 2 No

9. Birthplace (State or Foreign

Maryland

2008

Montgomery

Race - American Indian, Black, White, etc.

White

Specify:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□Unknown

24a. Was an autopsy performe 1∏ Yes 2 14 NO

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 □ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3∏ DOA 1 Hapatient 2 ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Doath 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier

1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) Name and

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

Registrar

State

SAHABAT

31. Date filed (Month, Day, Year)

POBOX

B, M, D,
32. Registrar's Signature

GRANTSVILLE, MD 21536

08-00055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jason Iseman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 3, 2008 0015 hrs Medical Examiner JASON WILLIAM ISEMAN 4c. County of Death 4a. Facility Name (if not institution, give street and number) The Memorial 4b. City, Town, or Location of Death Talbot 219 S. Washington St. Faston Hospital at Easton 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Linder 1 Year If Linder 24Hrs. **Funeral** oreign Months Days Hours Director Country) MD JULY 30,1974 212-19-9105 33 1**X** M 2 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No 28a-f show MD TALBOT TIT.GHMAN death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 21511 MISSION ROAD 21671 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Yes If Yes, Give Year Yes 2 X No specify: Specify: WHITE Widowed Δ Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 I permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: filem 27 is marked other than "Important traumatic event, the Medical. Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 1 WATERMAN SEAFOOD 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ EDGAR M. ISEMAN MARGARET LEDNUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDGAR M. ISEMAN/FATHER PO BOX 88, TILGHMAN, MD 21671 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) CHESAPEAKE CREMATION CTR 1/4/2008 STEVESNVILLE, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON. MD 21601 Ostasush m. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Narcotic and alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical #25a,PII,27,28a-f, perME,g875, 1/30/08 TT attending physician a X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown the that the 23e. Did tobacco use contribute to the cause of death? by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 ✔ Yes ۵ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Yes 2 X No unk within 24 hours after death. To the Funeral Director: Pending Fnd 1/2/2008 Fnd 11:19 pn 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 26709 Tunis Mills Rd. Faston, MD (Specify) found: private dwelling determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. January 3, 2008 Me D 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Ling Li, MD 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

State Registrar

Shah

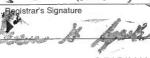
our B

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

temen



Thomas

ORIGINAL

29c. License number

D0060417

Johnson by Frederick MB

29d. Date signed (Month, Day, Year)

January 8, 2008

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM/31, perform (875, 1/14/08 WS)
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jan 6, 2008 4:35PM Minnigh Esther Laredo /Medical 4b. City, Town, or Location of Death 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) Examiner 36 E. Industrial Blvd Cumberland Allegany Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Deys Hours 1 □ M 2 □ F Jul 10, 1922 MD 214-16-2423 Director 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at Cumberland 1 ☐ Yes 2 ☐ No MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ıl Hygiene. other than "natural", or Items 23a or ' vent, the Medicai Examiner must be r 36 E. Industrial Blvd 21502 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify Completed by 3 X Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker i. Pages 1 and 2 should be filed w rtment of Health and Mental Hygie rtant: If item 27 Is marked other ti njury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Robert Smith Beatrice Crabtree Smith Twigg ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau MD 21502 Richard Minnigh Sr. 307 E. Reynolds St. Cumberland son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/10/2008 Hillcrest Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F neral Service License 22. Name end Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximate Interval Between Onset and Death I m ete Cause (Final dise e or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, franciscusse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant et time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should ! 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an Was al. autopsy performed? Yes 2 No 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IRGINIA AUE - CUMBERLAND MD 21502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QAISRANI OSHIN 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** HELEN LENORE MUELLER 2008 JANUARY 6. 8:46 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21 Austin Drive Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes 3/4/1914 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 X F Days Hours 93 Maryland 212**-**05-6196 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Instit: If item 27 is marked other than "natural", or items 23a or 28a-f show unit: If item 27 is marked other than "natural", or items 25a or 28a-f show unit of other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 USA 21 Austin Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Seco 12th çondary (0-12) College (1-4or 5+) Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Elliot Blanchard Helen Brennick ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Mueller/ Daughter 25 Hunting Ct., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or otl once. 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 1/9/08 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Suneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Immediate Cause (Final Physician disease or condition resulting in death) ule /Medicai Due to (or as a consequence of): Examiner vonance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 1□ Yes 2 1 M6 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 N 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27, Manner of Beath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and To the Funeral Div 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10 State 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 TIDEU

32, Registrar's Signature

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00091 State of Maryland / Department of Health and Mental Hygiene Jason Michael Mclaughlin 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2145 hrs January 3, 2008 Jason Michael McLaughlin Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Hagerstown Washington 11217 Tanglewood Ct. # 14 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Months Days 142-76-2151 Director Country) 1 X M 2 F Yrs 3. 1983 24 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Yes 2 X No 28a-f show 23a or 28a-f sho notified at once. Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11217 Tanglewood Court 21740 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noor items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes Specify: White Yes 2 X No specify: Divorced f Yes, Give Year event, the Medical Examiner Widowed "natural". ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene. ant: If item 27 is marked other than "" MD 21215-0036 12 Disabled 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Edward McLaughlin Wendy Ruth Hays 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael E. McLaughlin/father 20 Poplar Street, Myersville, MD 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State ltimore, rtant: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan.12, Mt. Olivet Cemetery 2008 Frederick, Maryland Other Specify Dogration 5 22. Name and Address of Facility 504 Main Street 21. Signature Funeral Arrice Licensee Ricketts Funeral Home Myersville, MD 21773 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or complication failure. List only one cause on each line. **Physician** Between Onset and /Medical Death Acute coronary artery dissection Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED PII, 27, perME, g875, 1/15/08 TT X UNPENDED attending physician or use as the burial -Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o s been signed by should be detach ⋛ Yes 2 No 3 Probably 4 ✔ Unknown Δ. Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has be director, page 2 sh death? performed? 2 ✓ Yes 2 1 V Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26 Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ Hospital: Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 FR/Outpatient 3 1 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E January 4, 2008

0

State Registrar 111 Penn Street, Baltimore, MD 21201

Mélissa Brassell, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	olalo ol marytani	Cei	rtificate of I	Death	Re	g. No. 7 1 1 1	00570	
	Physici		Decedent's Name (First, Middle, Last	"URSULA 1	PUM.	PHREY	1	2. Date of Death Month	Day 07 Year	3: Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	1. 201	
			12975 Monticello	Drive		Lusby			Calvert		
	Funeral Director		5. Social Security Number 6. Se 11 219-46-5643 Usual Residence of Decedent	7. Age (In yrs. Ia ☐ M 2 ☐ F	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09–14–1	Year) Cot	nplace (State or Foreign untry) many	
	land ow		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits	
	Mary Fred a	tor	MD Calvert			Lusby				1 ☐ Yes 2 💢 No	
	th the or 28%	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?	
	23a ust b		12975 Monticello	Drive		2065			USA		
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 Yes 2 No If Yes, Give Year or Dates:			Specify:			ite	
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9	filed I Hygi other ent, t	BeC	17. Father's Name (First, Middle, Last)			1119 02021	18. Mother's Name	(First, Middle, M	laiden Surname)		
ılar	uld be dental rked o	To B	Alfred Johann (Cramm			Johanna	August	e Seynsta	hl	
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T			-			City or Town, State, 2	ip Code)	
	es 1 and 2 of Health I Item 27 I		Patricia Ann Mill				as Drive,				
Baltimore,	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from State	metery, crei	sition (Name of matory or other plac	ce)		20c. Location - City or		
單	it. Pa intmer intant: injuny		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License			U.M. Cen Name and Addres	netery 1-		Solomons,		
Ba	permit. Departn Importa any Inju		21. Signature of Pulleral Service Licens	2 Cin			· Ko		neral Home	, P.A.	
			20 American Lane, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)	EU		ARUN			Onset and Death	
B	LAdiminet	<u></u>	Sequentially list conditions	b. Due to (or as a consequence	ence ot):						
k -	rted nsit	nine	Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or).						
, ,	rtificate be executed ng physician and as the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):						
68760,	te be ysicia e bur			d							
	rtificate be executed ng physician and s as the burial-transit	Medical	IF FEMALE:								
P.O. Box	w requires that the death ce been signed by the attendii should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year	
	ss that gned b	by Pł	Part II. Other significant conditions co	ontributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
ord	equire een si ould k	ted	<u> </u>					1X Yes	s 2∐ No 3∐ Pro	obably 4 □Unknown	
Division or Vital Records,	The lar	Completed						24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No	
Zit	Attending Physician: Threath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		otho	26. Place of Death			<u> </u>	
0	Phys r this ral di	- 1º	1 ☐ Yes 2 ☐ No 27. Manner of Death	I _ Inpatient 2 _ E	R/Outpatier 28b. Time of	IL 3 DOA	4 L Nursing Ho	me Resider 28d. Describe how	nce 6 Other (Spec w injury occurred	city)	
on	nding I th. :: After e funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,		
Jivis	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,		eet, factory, office	1	28f. Location (Str. City or Town,	reet and Number or Ru , State)	ral Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		ysician: To the best of my know iner: On the basis of examinati and manner stated.							
	To the within To the Comp	M	29b. Signature and title by certifier	us/llen.	MD	29c. Licens	S635	. 29	od. Date signed (Month	n, Day, Year)	
	6		30. Name and address of beison who c	completed cause of death (Item	23a) (Type/	er 900	Bestau	terd	Suffe	300	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure face	6.3	TY	natous	5, MJ 2	144	
	Registr	ar	JAN 1 4 2008	A SS .	A CONTRACTOR OF THE PARTY OF TH	400				-	

	,	For State Registrar	State of Marylan		rtificate of			iene eg.No. 2 ∩ ∩	0 00571	
Physici	an	Decedent's Name (First, Middle, Last Frederick	Kennedy		Price		2. Date of Deat January		3. Fine of Death 8:20 p M	
/Medica Examine		4a. Facility Name (If not institution, give				r Location of Death	January	4c. County of D	-	
Examin	161	Kline Hospice H	,			t Airy		Frede	rick	
Funeral Director		210 05 7100	ex	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, May 8,	1920 Pe	Birthplace (State or Foreign Country) ennsylvania	
Maryland a-f show iffed at	ctor	Usual Residence of Decedent 10a. State Maryland Tob. County Frederi		r, Town or Lor Freder					10d. Inside City Limits 1 Yes 2 □ No	
ath with the 23a or 28 ust be not	ral Director	10e. Street and Number 216 Rockwell Ten	race		10f. Zip Code	21701	0g. Citizen of What	-		
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▲ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 X Yes 2 □ No WOr If Yes, Give Year or Dates: War	ld	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 No	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:		
d 27275-(filed within 72 h Hygiene. other than "natu ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra	conpleted) College (1-4or 5+)	(Givo	ent's Usual Occup kind of work done OO NOT use retire eting &	during most of work	ing	16b. Kind of Busine Railroa		
Maryland 2 d 2 should be filed th and Mental Hyg f is marked other traumatic event.	To Be C	17. Father's Name (First, Middle, Last) Kennedy			18. Mother's Name		Maiden Surname) Louise Kress			
M62 allth all 27 is rtrau		19a. Informant's Name/Relationship (Topice,	Wife	216	Rockwell		, Freder	ick, Mary	1and 21701	
0 90 = 5		20a. Method of Disposition 1 Burial 2 Toremation 3 4 Donation 5 Other (Specify	Smi	Lthsbu		tory Jan 8	3, 2008		g, Maryland	
baltim permit. Pag Department Important: any injury o		21. Sign ture of Funeral Service Liver	Jew M0070	$\frac{1}{100}$	Keeney 6 Keeney 6	& Basford Church St.	P.A. Fu Freder	neral Homick. Marv	e land 21701	
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		n. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
/Medical Examiner	er	Sequentially list conditions b.							+	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):						
56/50 tificate be e g physiciar as the buri	ledical		•d							
O. BOX he death cer the attendir	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year	
ecords, P.O. law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions o	derlying cause giv	en in Part I.		cco use contribute to the cause of death?				
The law recate has bee	Completed			·			24a. Was a autops perform			
Or VITAI Physician: 7 this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ED/O-44	3 DOA Oth	26. Place of Death		4 .	Hospice	
on or or oding Phys th. : After this funeral dis		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	4 Inursing no	me 5 Reside 28d. Describe ho	ence 6 XOther (Sow injury occurred	House	
DIVISION tal or Attending s after death. al Director: Afte	Certification:	3 Suicido 6 Could not be						Street and Number or Rural Route Number, vn, State)		
To the Hospital or Attending F within 24 hours after death: To the Funeral Director: After completely filled in by the funer.	Medical (one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death tion and/or inv	estigation, in my	opinion, death occur	red at the time, d	ate and place, and	due to the cause(s)	
* Krok. Kaymen mg D-1397/ 1/									onth, Day, Year)	
10		30. Name and address of person who Robert L. Kaufmar	completed cause of death (Item nn, M.D., 300 V			et, Frede	erick, M	aryland 2	1701	
Sta Registr		31. Date filed (Month, Day, Year) 1AN 1 A 20	32 Registrar's Signa	ture	de			-		
DUMU 17 Day 1/0/	101	JAN 14 ZO	The second second	100						

			For State Registrar	State of Ma			ficate of L		тептат пу	Reg. No.2	008	00572
1	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Louis To	Ted Roberts			b. City, Town, or	Location of Death	Januar		2008 county of Deat	4:40 a. M
	Examili	11438 Woodland Way				Myersville					rederi	
A.S.	Funeral Director		5. Social Security Number 410-62-3751 Usual Residence of Decedent	ETM OFF	(In yrs. last birt		Months Days Hours Min.					thplace (State or Foreign ountry) INESSEE
	yland now at										10d. Inside City Limits	
	e Mar	ctor	Maryland Frederi		ville					1 ☐ Yes 2X No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 11438 Woodland Wa	У			10f. Zip Code 21773				en of What Co	ountry?
	er dea items	nue	11. Marital Status	12. Was Decedent E		13. Was	s Decedent of Hi es, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14	 Race - Ame Black, White 	
0000	urs aft al", or Exami		1 ☐ Never Married 2页 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	5	1 🗆	Yes 2∭X No		S	Specify: W	Thite	
5	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)		16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind	d of Business/	/Industry
7	within ene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		.) [NOT use retired, tainer) -	I		w Busi	ness
ם פ	I Hygid other rent, tl	Be Co	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·				18. Mother's Name	e (First, Middle	1		
yıand	Menta Menta arked	ToB	Louis Turner Ro	berts				Martha	Evelyn	Per	rin	
Mar	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (7 Marleen Brooks/wi	•••		_		and Number or Rur				,
baltimore, n	Healt Healt tem 27		20a. Method of Disposition	TTE			on (Name of lory or other place	d Way, My	Date		D ZI// ation - City or	
	Pages lent of nt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State					, 2008	Smith	isburg.	, Maryland
	permit. Departm Importa any Inju once.		21. Signature of Fu eral Sarvice icen			22. N	lame and Addres	ss of Facility	504	∔ Mair	Stree	et
	207 2 2		Ricketts Funeral Home Myersville, MD 21773									
		8 L	Unsmodiate Cause (Final								Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Due to (or s) consequence of):								I Week.	
	Examiner		Cognentially list conditions	b								
20	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	of):		1 41				
'n	execut and al-tran	Examiner	that initiated events c			ience of):						
00/00	tificate be executed g physician and as the burial-transit	edical E		d								
_	ertifica ing ph e as th		IF FEMALE:		,							
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	in the past 12 months? 1							3d. Date of de Month	llivery Day Year
7	s that ned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							e contribute to	o the cause of death?	
ecords	equire een sig ould b	ted b	COYONAM ONTON DISEASE 10 Yes 20 No 30							No 3□P	robably 4 Unknown	
Z Z	The law r te has be page 2 sh	Completed by	autopsy prior to							prior to death?	utopsy findings available completion of cause of	
<u> </u>	lan: T	Be Co	25. Was case referred to medical					26. Place of Deat	1 Yes h (Check only	one)	1 ∐ Yes	s 220 No
	hysici his ce il direc	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier		<u> </u>	3□ DOA Othe	4 LI Nursing He			□Other (Spe	ecify)
DIVISION OF	nding P th. : After t s funera		27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident Investigation	28a. Date of Injury (Month, Day		3b. Time of lnjury at Work? M 1 □ Yes 2 □ No						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined					(Street and wn, State)	et and Number or Rural Route Number, state)			
	e Hospit 124 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) CertifyIng Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state		death o	ccurred at the tin stigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) a , date and	and manner a place, and du	is stated. le to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date	signed (Mon	th, Day, Year)
			H	ron d.	Shoh		D	57643		100	9.08	5
	O_i		30. Name and address of person who	71	ath (Item 23a) (Type Pri	int)	Pale :				•
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	018	Daniel -	57643 PMD'C	SM	DO	2,703	
	Registr		JAN 14	2008	w St.	1	948)					

			For State					t of H	ealth a		ental Hygi	ene	008	00573
			Registrar 1. Decedent's Name (First, Middle	e. Last)			imour	0, 1			2. Date of Death		000	3. Time of Death
	Physicia		ESTHER TONGE		Ţ					Ì	January	Day 4	2008	7:06A M
8	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death		4c. C	ounty of Death	
	LAGITIII	C1	Laurelwood Nurs	sing Cente	er			E1	lkton				Ceci	1
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth Month, Day, 7/21/19	Year)	Cou	nplace (State or Foreign untry)
	Director		185-36-1882	1□M 2√□F	96	Yrs.	Wionina	Days	riodis		7/21/19	11′	Pen	nsýlvania
	pu »		Usuaf Residence of Decedent 10a. State 10b. County	_	10c C	ity. Town or Lo	reation							10d. Inside City Limits
	anyla •ho	5	PA York				ı Grov	ī A						1¶∑Yes 2 No
	the N	Director	10e. Street and Number			Lawi	10f. Zip				10	n. Citize	en of What Co	untry?
	with		5 South McDern	mott Road			101. 2.10		17321			· • · · · · ·	USA	
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in t	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14	1. Race - Amer	
٥	after or ite	교	1 Never Married 2 Mar	ied 1 ☐ Yes If Yes, Gi			tYes, spec 1 ☐ Yes 2				Hican, etc.)		Black, White	White
5	ours rai', c	d by	3€ Widowed 4 □ Divorced	Year or C	ates:		Tes a	5 K7 M0	эреспу.				Specify:	W11200
L	72 h "natu	ete	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece	dent's Usua kind of woi DO NOT us	il Occupa rk done d	ation during most	t of workii	ng	16b. Kind	d of Business/l	ndustry
21215-0036	filed within 72 hours after Hygiene. ither than "natural", or ite int, the Medical Exemina	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	Hor	nemake	eremed	,				Own	Home
2	filed Hygin other ent, I		17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, N	faiden S	(u <i>ma</i> me)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Manhal Hygiens and Manhal Hygiens is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	To Be	Henry Tonge						F.	Rae	Ashton			
аZ	should and Men marke umatic	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maifir	ng Address	(Street a	and Numbe	er or Rura	Route Number,	City or	Town, State, Z	(ip Code)
	and 2 Balth a n 27 is		Elizabeth Renw	ick/Daugh						E1k	ton, MD	219	921	
Baltimore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Bemoval from	20b.	Place of Dispo cemetery, cres	nsition (Nan matory or o	ne of ther plac	e)				ation - City or	
Ě	Pages ment of ant: if it lury or o		4 Donation 5 Dother (S	pecity)	Ce	entre Co	emete	cy	<u> </u>	1/11,	/2008	Nev	v Park,	PA
gail	permit. Pages 1 and 2 should Depertment of Health and Mer Important: If item 27 ie marke eny injury or other traumatic ance.		21. Signatur of Funeral Service	Licens/e	1/1		2. Name an				_	D 1.	D.3	17214
	ad 3 o d		gyguy	you	raused the de						, Inc.,		ca, PA	17314 Approximate
			28a. art1. Enter he disease, of shock, or heart failure. List immediate Cause (Final	only one cause on								, ,		Interval Between Onset and Death
83	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	5) LAG	>E [JEN	M Gr	700				
17	Examiner				T>	STAC	- 70		TRRI	VE				
		ner	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a conse									
4	cuted	Examiner	Cause (Disease or injury that initiated events	с.										
/60,	be executed sicien and burial-transit		resulting in death) Last	Due to	(or as a conse	quence of):							11	
687	# % e	dicai		d										
	leath certificat attending phy I for use as the	/Me	IF FEMALE:	23c. ff ves. ou	tcome of pregr	nancv						2.	3d. Date of deli	verv
O. Box	The law requires that the death certifica site has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth 2 Fel	tal death 3	Ectopic pr Other (sp						Month	Day Year
o.	that the de ned by the s detached t	hysi	1 U Yes 2 No 9 Unknown	9□ Unkr	own									
o. S	es tha igned I be det	by P	Part II. Other significant condition			-	nderlying c	ause give	en in Part I.		23e. Did tob	acco us		the cause of death?
ğ	w require been signaled by	ted	REZURA	(CETEL	57100						1 □ Y€	s 2/2	No 3∏Pr	obably 4 Unknown
ပ္မ	e law n has be je 2 sh	Completed	REZURA	677 (272						24a. Was a autops	y	prior to d	topsy findings available completion of cause of
<u> </u>	The l	Co									perform 1 ☐ Yes		death? 1 ☐ Yes	2E No
ĭ a	ysician: Th us certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital:				0#		of Death	(Check only on	e)		
0	Physical this call direct	10	1 Yes 2 No	28a. Date		☐ ER/Outpatier 28b. Time o			42 INU		me 5 Reside			cify)
CO	Attending Physician: r death. sctor: After this certifice by the funeral director.	tion	Natural 5 ☐ Pendir	ng / (Mor	nth, Day Year)	Injury	M	8c. Injury Work	k? Yes 2	_	EOU. Describe no	, w iiiiqui y	occurred	
Division of Vital Records,	after death after death Director: In by the	fica	3 ☐ Suicide 6 ☐ Could	not be 25e. Plac	e of Injury - At	home, farm, st							Number or Ru	ural Route Number,
á	al or after	Certification:	4 Homicide determ) build	ing, etc. (Spec	cify)					City or Towr	i, State)		
	To the Hospital or At within 24 hours after of To the Funaral Direct completely litted in by		29a. Certifier 1 Certifyi	ng Physician: To the Examiner: On the t	e best of my kr	nowledge, deat	h occurred	at the tin	ne, date an	nd place,	and due to the ca	ause(s) a	and manner as	stated.
	the H in 24 the Fi	edical	(1)	f and mar	ner stated.	Tation and/or in				IIII OCCUIT				
	To To To	Σ	29b. Signature and title of certific				1		number				signed (Monti	
ł			7/17	arn				127	073			07.	770 0	
	5		30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type,	Print)	٠ د	(-	10	NAN	Hつ ~	NE	19720
	Sta	te d	31. Date filed (Month, Day, Year,		Registrar's Sign	nature	ENT/YY	د ټو		/-	1 40 00	13/LE	170	11/20
	Registr		JAN 1 4	2008	was &	1								
_		_				-								

DHMH 17 Rev 1/2001

State Registrar SEVENTH OT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

CONNER

MO

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} Carl Early Shifflette, Jr. January 5, 2008 3:19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth (Month, Day, Year, Time 6, 1940) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**M**M 2□F Days 578-52-6554 67 Washington, DC Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State tems 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No **Funeral Director** Maryland Calvert Prince Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2905 Hallowing Point Road 20678 UNited States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Electrician US Coverment. al Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic eve Carl Early Shifflette, Sr. ပ Agnes Dolan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Hallowing Point Rd., Prince Frederick, MD 20678 Mary D. Shifflette / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John Vianney Cemetery 01/09/2008 Prince Frederick, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signatur of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. 4405 Broomes Island Road, Port Republic, MD 20676 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical truches Palmina **Examiner** Se guentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? es 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 hpatient 2 ER/Outpatient 3 DOA To the mosphise. within 24 hours after death. To the Funeral Director: After this of the funeral directors. L_O Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar

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31. Date filed (Morth, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 4

32. Registrar's Signature

D0061947

rick, md. 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Virignia Coshorn Sasse Jahlobbry 5 2008 423 P /Medical 4b. City, Town, or Location of Death 4a Eacility Name (If not institution, give street and number) 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ Months Days Director December 2, 1917 Washington DC 213–44–2723 90 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 → No Directo Maryland (Huntingtown Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18 Robshire Manor 20639 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ₩ Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie Farl Cornick Ora Virginia Cross ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Coshorn / Son 4527 Deer Park Dr., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/09/2008 Immanuel Cemetery Brandwine, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Pauso Funeral Home, P.A. 21. Signature of Funeral Service Licensee echael Kevin 4405 Broomes Island Road, Port Republic, MD 20676 laidmen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myo disease or condition resulting in death) Due to (or s a consequence of) /Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ျှ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

E. M40

29b. Signature and title of certifier

30. Name and address of person

who complet



One

cause of death (Item 23a) (Type, Print)

ORIGINAL

29d. Date signed (Month. Dav. Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Eileen Dorothy 4 January 2008 Stevens 10:55P "/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year)
June 23,1932 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X F Director 283-30-2924 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No "natural", or Items 23a or 28a-f st idical Examiner must be notified Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 291 Reams Drive 21158 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3X Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chauncey Hartshorn ပ Nellie Hines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Maas/ daughter 291 Reams Dr. Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State A11 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 1/5/2008 Sykesville, MD 21. Sign tu e of Funeral Service Lic 22. Name and Address of Facility Hartzler Funeral Home Junk attrans 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause in e Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IE FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy page perform 2 1 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: DOVE HOOSE 2 No Other: 1 Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury To the nospiral within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one e and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signat o completed cause of death (Item 23a) (Type, Print) Name and address of person w 555 WESTMINSTER CENTER 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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08-00121 Nona Sohn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

na Sohn		State of Maryland / Department Item 3 per me, 8877		Reg. No. 2008 0057
Physician	/ 1	Decedent's Name (First, Middle, Last) Nona Sohn	2. Date of De Month January	path Day Year 4, 2008 21 1408 hrs
edical Examin		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral	5	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24Hrs. 8, Date of	Birth (MM/DD/YYYY) 9. Birthplace (State or WeST
Director	- 1	294-22-3400 _{1 M 2 X F} 83	Yrs. Months Days Hours Min. Feb.	14,1924 Country) Virginia
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation na Park	10d. Inside City Limits 1 Yes 2 X No
yland y-f show	흱	MD Anne Arundel Sever	10f. Zip Code	10g. Citizen of What Country?
		394 North Drive	21146	USA No- 14. Race - American Indian, Black,
eath with items 2:	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after de ral", or liner m	고	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify: cedent's Usual Occupation (Give kind of work done	Specify: White 16b. Kind of Business/Industry
72 hours a	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working life. DO NOT use retired) ibrarian	National Security Agency
15-0036 filed within 72 Hygiene. d other than , the Medir I	d mo	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	lle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene, marked other than event, the Media	Be	Jacob E. Shaver 19a. Informant's Name/Relationship (Type, Print) 19b. I	Roxie Mae Ma	
MD 2 nd 2 should alth and M m 27 is m aumatic	٩	William B. Shaver/ Brother 29	7 Stowaway Lane Severna	Park, MD 21146
Fite Har		1 Burial 2 X Cremation 3 Removal from State crematory Metro	Disposition (Name of cemetery, or other place) Crematory Date Jan. 10,	
Baltimore, permit. Pages I an Department of He Important: If ite	1	4 Donation 5 Other Specify: 21. Signature of Lineral Service Licensee	22 Name and Address of Facility Barranco & Sons, P.A. S	Severna Park Funeral Home Severna Park, MD 21146
ന് ഉട്ടി≣ Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not	1 495 Gov. Ritchie HWY, S	severna rark, no zirao
kaminer	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Exsanguination		Death
			nary artery catherization	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause c.		
uted Id ransit	Exal	events resulting in death) Last Due to (or as a consequence of): d.		
iO, te be executed ysician and	edical		28a-f, perME,g876, 2/21/08 TT	23d. Date of delivery
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial transit	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
Box 6876 e death certificate the attending physical for use as the	Physic			Did tobacco use contribute to the cause of death?
, P.O. Box ires that the death signed by the att	by	Restrictive cardiomyopathy, pulmonary	artery hypertension 1	Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the law for death. "In Director: After this certificate has been signed by the funeral director, page 2 should be detach	Completed			Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
	Com	25. Was case referred to medical	1 ✓ 26.Place of Death (Check only one)	Yes 2 No 1 ✓ Yes 2 No
Vital Tysician This cert	ှ မြ	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other Nursing Home	estibo how injury occurred
on of Vi nding Physi th. r: After this	ion: T		1 Yes 2 X No perfo	pracedure
ivisic or Atter after dea Director	Certification:	2 X Accident Investigation 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc. 28f. Loc.	ation (Street and Number or Rural Route Number, City own, State) ersity Hospital, Baltimore, MD
ospi hou mer y fil			the second of the time date and place, and due to the	ne cause(s) and manner as stated.
To the Hos within 24 h To the Fun completely	Medical	Certifying Physician: To the best of my knowledge, det (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated, 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred at the time	29d. Date signed (Month, Day, Year)
	2	Pameto Surffer 11. md	O.C.M.E.	January 5, 2008
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine	r 111 Penn Street, Baltimore, MD 212	201
	State	e 31. Date filed (Month, Day, Year) 9 2008 32. Re istrar's Signature		
Reai	312	TO COLIN O WILLIAM TO THE TOTAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day January 7, 2008 Gloria Marie Tortorelli Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT 1835 Oriole Way St. Leonard 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2√F Months 194-28-5378 Director Pennsylvania August 4, 1938 69 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Calvert St. Leanard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1835 Oriole Way 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itea any injury or other traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical US Covernment 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Alfred E. Goehringer Marie Mathews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Tortorelli / Husband 1835 Oriole Way, St. Leonard, MD 20685 20b. Place of Disposition (Name of 2008 20c. Location - City of Toning. Service Alexandria Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Jan 9 Metropolitan Funeral 1 ☐ Burial 2 ☐ Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Inichael Keven 4405 Broomes Island Road, Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUMA Canst **Physician** /Medical Due to for as a consequence of) Examiner Obstructive Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Division or Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed?, 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural s after dea... al Director: After 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D the Hospital Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

3/

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 14

David J. Tardio, MD 14090 Solomons Island Rd., Suite 2500, Solomons, MD 20688

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

047610

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month /04/2008 7:15 Рм Lee Lehman Travers, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Dorchester General Hospital Cambridge If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/19/1937 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Maryland Days 1 X M 2 □ F 70 218-34-8495 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Hoopersville Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21634 1820 Hoopersville Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates; 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sally Mae Lewis Lee Lehman Travers, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Hoopersville Rd., Hoopersville, MD 21634 Lessie R. Coulbourne/Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DorchesterMemorialPark 01/08/2008 Cambridge, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Curran-Bromwell Funeral Home, P.A 308 High St., Cambridge, MD 21613 gnature of Funeral Service Licensee 23. Part1. Enter the discase, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line.

Immediate Cause (Final disease or condition and the cause of the condition and the cause of the condition and the cause of the cau Approximate Interval Between Onset and Death 80 monory disease or condition resulting in death) Due to (or as of nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo Phpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or r must be n

r than "natural", or items the Medical Examiner mu

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any linjury or other traumatic evonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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death with the Maryland

Physician/Medical

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Completed

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Certification:

Medical

the attending pl

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

in 24 hours. the Funeral Dire

within 2.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

H51793

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

2008

Eugene Newmier D.O., 503 Byrn St., Cambridge, MD 21613 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

		ı.	1 - State Henrick #18 Per F			•	rtment of H tificate of L		Mental Hygie	ne 008	00581
			Decedent's Name (First, Middle,		20,00 002				2. Date of Death		3. Time of Death
	Physici /Medic		Ruby Edith Wea	ver					Januacy (08, 2008	
	Examin		4a. Facility Name (If not institution,		ımber)		4b. City, Town, or	Location of Death		4c. County of D	
			Williamsport Nu		ne		William			Washir	
	Funeral Director		5. Social Security Number 220-16-1365	i.Sex 1 □ M 2 X 0 F	7. Age (In yrs. las	s <i>t birthday)</i> 90 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You December 5.	eari i	Birthplace (State or Foreign Country)
			Usual Residence of Decedent			70			ور عدهادددم	1717	10
	how		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Be-f s	Director	MD Washing	ton	Wi	lliam	-				1 XYes 2 No
	with the		10e. Street and Number				10f. Zip Code			. Citizen of Wha	t Country?
	a 23e	erai	154 N. Artizan		cedent Ever in U.S.	12 1	21795 - Vas Decedent of Hi			USA 14 Bace : A	American Indian,
	ter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F		. 13. 1	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Vhite, etc.
93	be filed within 72 hours after death with the Marylend the Hygiene, and Hygiene, of clear a 23a or 28e-f ahow dother than "natural", or itama 23a or 28e-f ahow avent, the Madical Examiner rivet be notilised at	þ	3 Widowed 4 □ Divorced	If Yes, G Year or I	ive	1	☐Yes 2☐XNo	Specify:		Specify:	White
- 2	72 ho	Completed	15. Decedent's (Specify only highest				ent's Usual Occupa		sina 16	b. Kind of Busine	ess/Industry
2	han han	dr je	Elementary/Secondary (0-12)	1	(1-4or 5+)	life. L	OO NOT use retired)			V
2	filed w Hygier Other ti		17. Father's Name (First, Middle, La	etl		Assen	olec	18 Mother's Nam	A A A A A A A A A A A A A A A A A A A		Manufacture
=	id be f entel } ked ol ic ave	To Be	Ralph Keefer	131/					v Millec	Mary Mi	lls
ary	is 1 and 2 should be of Heelth and Mentel Itam 27 is marked of other traumatic ave	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rui	ral Route Number, C	City or Town, Sta	te, Zip Code)
	1 and 2 Heelth a tam 27 is		Cacol L. Smith/N	iece		1100 (01d 126 W	ar fordsb	urg, PA 1	7267	
ore	ges 1 it of He if Itan or oth		20a. Method of Disposition 1	Removal from		ce of Dispon metery, crem	sition <i>(Name of</i> natory or other plac	e)		c. Location · City	
Ĕ	Pages ment of ant: if it ury or o		4 Donation 5 Other (Spe		Jeru	salen	Christia	n = 01/1	0/2008 Wa	cfordsb	irg, PA
Baltimore,	permit. Page Depertment of important: if any injury or once.		21. Signatural of Funeral Service Li	centree			Name and Addres	•	141 West R		reet 21750-0368
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that	caused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arrest		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Λ	JEUMONI						Onset and Death
	/Medical Examiner		resulting in death)		(or as a conseque	_					, , , , ,
И	LXammer	er	Sequentially list conditions,	b	(or as a conseque	200.20					
مار	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D0010	(ur as a conseque	illoar Sty.					
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conseque	ince of):					
8760,	cate be executed physician and the burial-transit	dical		d	_						
		edi			atulia					No.	
Вох	death certifi ie attending j od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnand birth 2 Petal d		Ectopic pregnancy			23d. Date of	-
o O	the deal by the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown		nant at time of dea		Other (specify)			Month	Day Year
a .	thet the de led by the a detached t	P.	Part II. Other significant condition	s contributing to	death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribu	te to the cause of death?
Records,	8 60	d by	ENDSTAGE S	SENILE	DEMEA		, ,		1 ☐ Yes	2/2 No 3	Probably 4 Unknown
S S	w requir been si should I	ete	Prince the	د من سوسی در					24a. Was an	24h Wer	e autopsy findings available
\mathbf{r}	0 - 0	Completed	PENITU IN	WFFICI	ENCL				autopsy performe	d? prior	to completion of cause of h?
	ilcien: Th certificate rector, pag	0	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2 ⅓ th (Check only one)	1No 1U	Yes 2□ No
≥	Physicien: rthis certific ral director,	To B	examiner? 1 Des 25 No	Hospital: 1	Inpatient 2 E	R/Outpatien	t 3 DOA Othe		ome 5 Residence	e 6 □Other (Specify)
n of	tanding Ph leath. tor: After th the funeral		27. Menner of Death 1 ★ Natural 5 Pending	28a. Date (Mo	of Injury 2 nth, Day Year) 2	8b. Time of Injury	28c. Injury Work		28d. Describe how		
Sio	Attanding ir death. actor: After by the fune	cati	2 ☐ Accident investiga	t be				Yes 2 □ No			
Division	- 0 T	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 288. Plac	e of Injury - At hom ding, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,
	To the Hospitai or A within 24 hours after To the Funeral Directompletely filled in by		288 Cartifier to Certifying	Physician: To th	ia best of my knowl	ladge, death	occurred at the fin	ne data and place	and due to the cour	se(s) and traine	or as stated
	ha Ho n 24 l ha Fu	edical	(Check only 2 Medical E.	kaminer: On the and ma	basis of examination nner stated.	on and/or inv	restigation, in my of	pinion, death occur	rred at the time, date	and place, and	due to the cause(s)
	To the to the comp	ž	29b. Signature and title of certifier	~			29c. License		29d	. Date signed (N	fonth, Day, Year)
•			Expone	CM S			D3.	3700	JA	ANUARY	9, 2008
	2		30. Name and address of person w			0				D= 4:	مرحد د ۸
			JED E, HOW? 31. Date filed (Month, Day, Year)		54 N.	HZT	IZAN S	5T. W11	LIAMSPO	KI, M	1) CIM5
	Sta Registr		1/1 1 A	2008		A STATE	and of				

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or Print in Black indelible ink. Ensure All Copies Are Legible.	00500
of Maryland / Department of Health and Mental Hygiene	00582
Cartificate of Dooth	

			1 - For State Registrar 1. Decedent's Name (First, Middle		Maryland	/ Depa	artment o	of Health and Not Death	Mental Hyg	jiene- U leg. No.	08	0 0 5 8
	Physic /Med	cai	Rose M. Willia	ms					Month O1	/04/20		10:05 A
1	Exami Funeral		4a. Facility Name (If not institution 29972 Holly Acr 5. Social Security Number	es Rd.	r) Age (In yrs. las	it birthdav)	Tra	wn, or Location of Death APPE 'ear If Under 24 Hrs.	8. Date of Birth	Ta	y of Death 1bot	place (State or Forei
	Director		185-28-0952 Usual Residence of Decedent	1□M 2XF	71	Yrs.	Months D	ays Hours Min.	July 21	, 1936	Penn	olace (State or Foreigntry) Sylvania
	Maryland	tor	10a. State 10b. County Maryland Tal	bot	10c. City, 1	Town or Lo	ocation Trap	ppe			1	1 Yes 2
	th with the 23a or 28	ai Direc	10e. Street and Number 29972 Holly Ac	res Rd.		·	10f. Zip Co	21673		l 0g. Citizen of	What Coul	-
980	be filed within 72 hours after death with the Maryland NaI Hygiene. Indicate than "nature!, or items 23a or 28a-f show event, the Medical Examiner count by notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? No		Was Decedent If Yes, specify	t of Hispanic Origin? (Sr Cuban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americack, White,	
21215-0036	l within 72 hc iene. rthen "natur ihe Medical	ompleted	15. Deceden (Specify only higher Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or	r 5+)	(Give life.		occupation lone during most of work etired) Owner/Waitr		16b. Kind of E	Business/In	
Maryland 2	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Thomas Liberto	Last)				18. Mother's Nam				
	s 1 end 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relations Jamie Giuffrida					treet and Number or Rui $ m lly~Acres~R$				
Baltimore,	Page nent o ant: if ary or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		e cem	etery, crei	osition (Name of matory or other remation	onCenter 1.		20c. Location Cambr		
Balt	permit. Departrimports eny inje		21. Signature of Funeral Service	1.0		22 M	Name and A	ddress of Facility	n Conton	DO D	ox 14 21613	64,
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart fast fre. List Immediate Cause (Final disease or condition resulting in death)	-a. Lun		anc	er the mode of	dying, such as cardiac	or respiratory arr	est,	21010	Approximate Interval Between Onset and Death
₩- 0	ate be executed hysicien and he burial-transit	Examiner	Sequentially list conditions, any latent of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequen							
D. Box 68760,	it the death certificate be by the ettending physici tached for use es the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 the control of the contr	d	2 Fetal de	ath 3	Ectopic pregn Other (specif				ate of delive	ery Day Year
ords, P.O	The law requires that th ite hes been signed by I bage 2 should be detach	þ	Part II. Other significant condition			0.	nderlying caus	e given in Part I.	23e. Did tol			ne cause of death?
al Records,		Completed							24a. Was a autops perform	ned?	Were auto prior to co death? 1 \(\subseteq Yes	psy findings availab mpletion of cause of 2□ No
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:				Other: 4 D Nursing He		577		
o	Phys this ral di	tion: To	1 Yes 2 No 27. Manner Death 1 atural 5 Pendin 2 Accident investig	28a. Date of Inju	ient 2 ☐ ER ury 28 ay Year)	Outpatien Bb. Time of Injury	28c.	Injury at Work?	ome 5 eside 28d. Describe ho			y)
Division	i or Attending after death. Director: After I in by the fune	ertification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	ot be 28e. Place of In	njury - At home tc. (Specity)	e, farm, str			28f. Location (Si City or Town	reet and Num n, State)	ber or Rura	Il Route Number,

To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate hes been six completely filled in by the funeral director, page 2 should t Be Completed Medical Certification: To

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number H47357

29d. Date signed (Month, Day, Year) 01-04-2008

Do 8221 Teal Dr. Stute 204 Easton, MD 21601 O. Name and

Trady

31. Date filed (Month, Day, Year) JAN 1 4 2008



State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

/Medical Examiner the Hospital or Attending Physlcian: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760. physician as attending properties for use as ed by the a

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.

Physician

Baltimore, Maryland 21215-0036

page 2 s certificate director, this After d in by the f within 24 hours are
To the Funeral Dir

Physician/Medical ρ Completed Be ို

Certification:

State

Medical

31. Date filed

5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06039 MO 008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEEB

100 PRINCE FREDERICK JABER HUSP MAL 32. Registrar's Signature

Registrar

Registrar DHMH 17 Rev 1/2001

10

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVSRAIALLI HARISH*

2008

5

32. Registrar's Signature

VVERAIZALLI

JAN

31. Date filed (Month, Day, Year)

TRESWATRON

5401

BOSPITAL

OLD COURT ROAD

CENTER.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 205PM Month **Physician** ernon /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SINA HOSPITIAL BALTIMOPE OF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Pay, Year) yrs. last birthday Birthplace (State or Foreign Country) Social Securify Number 7. Age (In **Funeral** Days Hours Months **™**M 2□F 505-20-5763 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 Nes 2 No timore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number rat", or items 23a or Examiner must be r 21215 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Yes, Give 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No r Yes, Give Year or Dates: à 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTOse retired) marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr condary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surn. Middle Last Be ဥ altimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGRESTIVE HUMET /Medical Due to (or as a consequence of): Examiner PALLUR PENBL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death ed by the a detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NEPATITI 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CONTIULOPATHI 24a. Was an has autopsy performed? res 2 certificate ha 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 22/14 Other: ျှ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No dea h. within 24 hours after death

To the Funeral Director...

completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061959 30. Name and address of winson who completed cause of death (Item 23a) (Type, Print) AVE, SINA HOSPITAL OF BOLTIMORE IN DELVE DERE 2401 MMAN SIBOL Mb 31. Date filed (Mon 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-00381 Sean Joseph Be	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bergin State of Maryland / Department of Health and Mental Hygiene 2008 0586									
		- For State Registrar		g. No.						
Physicia Medical Examir	ner	Decedent's Name (First, Middle,Last) Sean Joseph Bergin Aa. Facility Name (if not institution, give street and number)	4b. C	ity, Town, or Location of	2. Date of Death Month January 13	Day Year	3. Time of Death 2206 hrs		
		1247 Williams Street	,	l l	altimore					
Funeral Director		217-90-5254 1XM 2F	ge (In yrs. last i		Under 1 Year If Under onths Days Hours	Min	h(MM/DD/YYYY) 9. Bir Foreig 0, 1967 Co	hplace (State or n Maryland untry)		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tox	wn or Location				10d. Inside City Limits		
*	٦	Maryland N/A]	Baltimon	e			1 XYes 2 No		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1247 Williams Street		10	. Zip Code 21230	10	og. Citizen of What Cou USA	ntry?		
the nat	eral	11. Marital Status 1 X Never Married 2 Married Armed Forces	?		cedent of Hispanic Origin pecify Cuban, Mexican, I		14. Race - Amer White, etc.	can Indian, Black,		
ler dea	필	3 Widowed 4 Divorced If Yes, Give Yeer	X No	1 Yes	2 X No specify:		Specify: Whi	te		
ours af	Completed by Funeral	15. Decedent's Education (Specify only highest grade co	mpleted) 16	a. Decedent's U	sual Occupation (Give ki		16b. Kind of Business/			
6 n 72 ho an "na ical Es	lete	Elementary/Secondary (0-12) College (1-4 or	5+)	Managei	f working life. DO NOT u	ise retired)	Food Indu	strv		
-003 I withii giene. her th	E .	12 17. Father's Name (First, Middle, Last)		Tanage		Name (First, Middle, N				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Patrick J. Bergin Sr.				y Ann Meier				
21 hould then and Merris marris marring even	리	19a. Informant's Name/Relationship (Type, Print)			dress (Street and Numb					
, MD and 2 sho ealth and em 27 is		Linda Reich, Sister 20a. Method of Disposition			Name of cemetery,	d Catonsvil	le, Maryla 20c. Location - City or			
altimore, mit. Pages I ar ppartment of Hee pportant: If ite	ï	1 XBurial 2 Cremation 3 Removal from S	tate crer	matory or other p	lace)					
Iltim nit. Pa artmen ortant	-	4 Donation 5 Other Specify: 21. Signature of Funeral Sergice Licensee	WOO	dlawn Co		01/17/08	Woodlawn,			
Per Dept Imp	Ч	Thomas Gregor (Mac 301	Madd Funera Frederick l	Road Catons	sville, Mar	yland 21228		
Physician /Medical Examiner		Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscle)		not enter the m	ode of dying, such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death		
ÇXAIIIIICI	اير	or condition resulting in death) Due to (or as a consequentially list conditions,								
.}/ _	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying indeath (or as a constitution).						-		
e executed cian and irial - transit	평	d. X UNPENDED AMENDED ALCOHOLO A	erME.g876	5. 2/25/08	TT					
760 ficate b	/Me	IF FEMALE: 23c. If yes, outcome		псу		prognancy	23d. Date of deliver			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Physician/Medi	past 12 months?	t time of death	2 Fetal d	(Specify)	pregnancy	Month	Day Year		
ires that the signed by t	ģ	Part II. Other significant conditions contributing to dea	th but not resu	Iting in the unde	rlying cause given in Par		bacco use contribute to	_		
Division of Vital Records, rater death. To after death. To Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed					24a. Was autop		utopsy findings available completion of cause of		
Reco The law icate has	dmc						rmed? death?			
ital Recipion: The certificate	BeC	25. Was case referred to medical			26.Place of Death (
Vit		TV Tes 2 NO		R/Outpatient 3	DOA Other		Residence 6 Othe	er: Scene		
ion of \\ itending Phy leath. tor: After tl	ü	27. Manner of Death 1 X Natural 5 Pending	Year)	Bb. Time of Injury	28c. Injury at Work?		how injury occurred			
risio	ficat	2 Accident Investigation 28e. Place of	njury - At home	e, farm, street, fa	ctory, office building, etc		Street and Number or R	ural Route Number, City		
Divis pital or At ours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	State)			
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the 1	Medical C	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of example and manner stated	amination and/							
FSFÖ	ž	29b. Signature and title of certifier			29c. License number		29d. Date signed (Me			
		Jank 1300	mo		O.C.M.E.		January 14, 200	8		
ϕ		30. Name and address of per who completed bus of Tasha Greenberg MD. Assistant Medic	cal Examine	•	nn Street, Baltimor	re, MD 21201				
Sta Regist	ate rar	31. Date filed (Month PaylYeer) 2008 32 Registr	ar's Signature	South	В			77.0		
1.09131	-									

7. Age (In yrs. last birthday)

79

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00587 State of Maryland / Department of Health and Mental Hygien 🖸 🖯 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 JANUARY 2008 BLAUSTEIN 2:25P M **JOSEPH**

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

TOWSON

4c. County of Death

8. Date of Birth (Month, Day, Year) 08/21/1928

BALTIMORE

Birthplace (State or Foreign Country)

GERMANY

Physician	
/Medical	
Examiner	

4a. Facility Name (If not institution, give street and number)

6. Sex 1 💢 M 2 🗆 F

MANOR CARE - RUXTON

5. Social Security Number

212-30-5718

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, the Mudical Examination in the following.

Enysician

Baltimore, Maryland 21215-0036

/Medical **Examiner** To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certilica

Division of Vital Records, P.O. Box 68760,

	Usual Residence of Decedent										
	10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside City Limits	
101	MD BALT	IMORE	BA	LTIMORE						1 ☐ Yes 2 💢 No	
runeral Director	10e. Street and Number			10f. 2	Zip Code			10g. Ci	itizen of What Co	ountry?	
ם כ	6 LONGSTREAM CO	URT, #202			2120)9			US/	Δ	
ē	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dec	cedent of Hisp pecify Cuban.	anic Origin? (: Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit		
	1 Never Married 2 Marrie 3 🔀 Widowed 4 Divorced					Specify:	,			WHITE	
ופופח	15. Decedent's (Specify only highest	Education grade completed)	16a	. Decedent's U: (Give kind of life, DO NOT	work done dur		orking	16b. h	Kind of Business	/Industry	
combiered by	Elementary/Secondary (0-12)	College (1-4or	5+)		SALES				FUI	RNITURE	
מ	17. Father's Name (First, Middle, L		AUGTETN				me (First, Middle	e, Maidei		TATNADIE	
2	KURT		AUSTEIN			ELSA		0.7		TAINABLE	
	19a. Informant's Name/Relationshi			_			iural Route Numb				
1	EDWARD BLAUSTEIN / SON 18502 FIDDLELEAF TERRACE, OLNEY, MD 20832 20a. Method of Disposition (Name of Date 20c. Location - City or Town										
	1 X Burial 2 Cremation 4 Donation 5 Other (Sp		cemete	ery, crematory of IMORE H	or other place)	01/1	3/2008				
	21. Signatura of Funeral Service L	1-/-	DALI			of Facility SC	L LEVIN	SON	& BROS.	. INC.	
	MAICHARD	Mus a	2							MD 21208	
	23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that ceuse	d the death. Do	not enter the m	node of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Between	
	Immediate Cause (Final disease or condition	CON	GEST	IVE	and	150	CHEM	1/		Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE and SSCHEMIC Due to (or as a consequence of): CARDIOMYOFATHY										
	Sequentially list conditions,	U.	KDIO a consequence		VA.	177				/	
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (0) as	a consequence	01).							
Examme	that initiated events resulting in death) Last	c Due to (or as	a consequence	of):			,				
		d									
E C	IF FEMALE:								110		
rilysiciallymedical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal deat	h 3 Ectopia 5 Other	pregnancy (specify)				23d. Date of de Month	olivery Day Year	
Ĺ	Part II. Other significant condition	e contributing to death h	out not resulting	in the underhie	a cause awen	in Part I	23e Did	tobacco	use contribute t	o the cause of death?	
our bieren by	Part II. Other significant condition	is contributing to death t	out not resulting	in the undertying	g cause given	III F alt I.		Yes 2		robably 4 Unknow	
יינו							24a. Wa	5 20	24h Were a	utopsy findings availabl	
							auto	opsy formed?	prior to death?	completion of cause of	
5	25. Was case referred to medical					6 Place of De	1 Yes		o 1 L Yes	s 2 No	
	examiner?	Hospital: 1 ☐ Inpati	ent 2□ER/0	Sutnationt 3	DOA Other:		eath (Check only Home 5 - Res		6 DOther (Sne	acity)	
-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury a Work?		28d. Describe			Johny	
al III ca	2 Accident investigation of Could not determine a contract of the contract of the contract o	ot be 28e. Place of in	jury - At home, t tc. (Specify)			2 2 3 110	28f. Location City or To			lural Route Number,	
edical cel lineallon.	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner st	of examination a	ge, death occurr nd/or investigati	ed at the time, ion, in my opin	date and place ion, death occ	ce, and due to the curred at the time	e cause(, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
INC	29b. Signature and title of certifier	Chiladia		1	29c. License r	umber	469	29d. D	ate signed (Mon	th, Day, Year)	
	1///10	- wicevin			a - c c	100	//		,		
	30. Name and address of person w	ho completed cause of	death (Item 23a)	(Type, Print)	LER	Dr.	10 W	501	1 172	08	

State Registrar

31. Date filed (Month, Day, Year)

7600

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 7:20 a M Clyde January 2008 Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 14 1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Min. Days Hours Hawaii 79 Director 576**-**26-6838 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 24 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 21060 127 Martha Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other th jury or other traumatic event, th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bryant unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Ember Drive, Pasadena, MD Robert Clyde - Son 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: If any Injury or 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 1/14/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Williams Hill 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a la consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death 1 ☐ Live birth in the past 2 months? Month Day 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cate has been significant page 2 should b 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐Yes 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; completely

15

State Registrar 29b. Signature and title

29d. Date signed (Month, Day, Year)

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel

and manner stated.

WD HRD OUN 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 4:10 AM January 13 Alan Marsh Chedester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 5033 Dover Court Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1**⊠**M 2□F 228-52-8761 67 Washington, DC Director Feb. 7,1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No notifled Director Howard Maryland 28a-f Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö must be 5033 Dover Court 21044 U.S.A. Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank M. Chedester Florence Boyst ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sara W. Chedester (Wife) 5033 Dover Court Columbia, MD 21044 20b. Place of Disposition (Name of Columbia Memorial) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 1-16-2007 Clarksville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc MO1050 Madema 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** o years disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physiciar IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Vear 5 ☐ Other (specify) been signed by the should be detached in ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEXNO 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an was and autopsy performed?
Yes 2 No certificate has trector, page 2 s 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home **3**2 № No Medical Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir To the Hospital 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 31. Date filed (Month, Day, Year) 32. Rebistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Collins **Physician** 15e 9 2008 1:00A January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July 25,1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 TF 219-64-4229 Germany 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County or 28a-f show be notified at 10a State 1 ☐Yes 2 ➡No Howard Glenwood Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21738 U.S.A. 3327 Danmark Drive Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "naturar", or items 23s ury or other traumatic event, the Medical Examiner must. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 2 White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hotel Regina Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Muller Maria Kretschmeier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3327 Danmark Drive Glenwood, MD 21738 Michael Collins (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arlington National 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once, 4 Donation 5 Dother (Specify) 2-21-2008 Arlington, Virginia Cemetery ^{22 Name and Address of Facility} Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licensee M01054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ementia Immediate Cause (Final disease or condition resulting in death) years Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine-trace cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to E-riss a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 **X**No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes H-2-11 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🔲 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ivino Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deatl 28c. Injury at Work? After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 8600 Snowden River ste 301, Columbia MD 21045 DKWY 21

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Régistrar's Signature

			Amend #6,1	Please 3,perFH,G	Type or P 876 2/21/0 State of	rint in E	Black In	delible lnk.	Ensure A	II Copies	Are Leg	gible.		
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			504 Ca 5. Social Security Nu	lvin L		. Age (In yrs.	last hirthday)	Rocky If Under 1 Year	ille M If Under 24 Hrs.	8. Date of Birtl		gome 9. Birt	hplace (State or	Foreign
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	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. It Health and Merital Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ō	MD		gomery		ckvil						1XX Yes	
	the N 28a- notifi	Director	10e. Street and Num		3011101	110	CILVII	10f. Zip Code			10g. Citizen o	of What Co	untry?	
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36	or it	by Fu	1 Never Marrie		1 ☐ Yes 2 If Yes, Give Year or Dat	No No		1 X Y ∞ 2 X No	Specify:			cify: Wh	nite	
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J.	t and Health tem 27 other tr		20a. Method of Disp		ws/Mothe	20h F	Place of Dien	kville,	i .	$1^{0}/11/08$	20c. Locatio	n - City or	Town, State	
3 E	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other			□Cremation 3 5 □ Other (Spe	☐Removal from St	tate Hov	ward 1	matory or other pla Univ., 3	ijeged.	1,11,00	Washi	ngto	on,DC	
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	Physician		23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	rt failure. List or Fin	a	ch line. Zure		ter the mode of dyi	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	/Medical Examiner		resulting in death,	(0 3	r as a conseq	Cit a	arral						
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O. Box 6876	Attending Physician: The law requires that the death certificate be executed reath: death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		rth 2 ☐ Feta ant at time of o	al death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y		23d.	Date of de Month	,	'ear
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1	i or A after Direction by	ertif	4 ☐ Homicide	determin	ed buildin	ig, etc. (Speci	ify)			City or Tou	vn, State)			
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one)	1 X Certifying 2 ☐ Medical E	Physician: To the la xaminer: On the ba and mann	sis of examina	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner a .ce, and du	s stated. e to the cause(s)
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	1		30. Name and addr			of death (Ite	m 23a) (Type		Vest Edn			ve,	Suite	403
-	7		Martha 31. Date filed (Mon			gistrar's Sign	ature		ville,	MD 20	852			
	Sta Regist	ate rar	51. Date theu (WOII	IAN 15	2008	gistrar's Sign	N A	porte						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 par doc 8875 1-15-08 yt
State of Maryland 8 bepartment of Health and Mental Hygiene

December March M				1 - State Registrar Certificate of I	Death	Reg. N	№2 <u>108</u>	00592
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Provided Board Section Foreign Country CENERAL HOSPITAL Columbia Country Count	2	/Medic	al		- Landing of Booth	Januar	4 11 2008	3.301 M
Social Social Control March Social Control March Social Control		Examin	er			•		
Directors Control Co	_2	Funeral				B. Date of Birth	9. Birthpl	ace (State or Foreign
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Richard D. Love Special Prince Dorothy J. Marsh Special Dorothy J. Marsh	ည	72 ho natur lical	eted	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done)	ation during most of working	16b.	Kind of Business/Ind	ustry
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23a. Pent. Enter the disease, or combiodions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, individual provided in the past 12 moons of the past 12 moo	ē,	of Hear item othe		20a. Method of Disposition 20b. Place of Disposition (Name of				
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Physician Medical Examiner Physician Medical Examiner The Bull Service of the S	20	20 = 20		3204 Mount	tain Road,	Pasadena	, Maryland	
Physician (Medical Examiner) The guesting to information of the control of the c	F. 5			shock, or heart failure. List only grie cause on each line.	ng, such as cardiac or r	respiratory arrest,		Interval Between
Sequentially list conditions, farry, leading to invincionate cause. Enter Underlying. End Abage. Bunch Dir Cabb. Due to (or as a consequence of): Chrom to Ohn Truchiv. Full morney. Dir flower. 23d. Date of delivery. Month Day Year 1 Ves 2 No 3 Probably Volunknown 24a. Was an autogray. 24b. Were autopsy findings available prior in completion of cause of a large of the completion of cause of a	2						9	Onsot and Death
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TE SO TO TO TO THE DESCRIPTION OF THE DESCRIPTION O	<u>s</u>	ttend death. :tor: /	cati	3 Suicide 6 Could not be 280 Place of injury. At home form street, fectory office		of Logation (Ctreat	and Number of Dise	I Paula Number
29a. Certifier 1 29certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	\leq	after o	ertifi	datarminad 200. I lace of fillery Actionic, lattin, street, lactory, office	201			noute Number,
Check only one Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cack River Welk Road Backton 201-107 Scak River Welk Road Backton 201-201 31. Date filed (Month, Day, Year) 32. Sepistrar's Signature 33. Date filed (Month, Day, Year) 32. Sepistrar's Signature 34. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Sepistrar's Signature 36. Sepistrar's S		spita lours neral / fillec						
29b. Signature and title of certifier 29c. License number D 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rams is Sabapathi 201-109 (Scale River Neele Road Baltimore Manyland 21221 State Registrar 31. Date filed (Month, Day, Year) AN 1 5 2008 29c. License number D 30641 29d. Date signed (Month, Day, Year) January 12 2008 32. Registrar's Signature AN 1 5 2008		n 24 h	edic	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my cone and manner stated.	pinion, death occurred	d at the time, date a	and place, and due to	the cause(s)
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State Registrar 30. Name an

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address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	•	For State Registrar	State of Maryland		rtment of F tificate of			giene Reg. Nd.)	000	nnsal
Physicia		1. Decedent's Name (First, Middle, Last)			Car	^	2. Date of De Month	path Day	Year 200 %	3. Time of Death
/Medic Examin	-	4a. Facility Name (If not institution, give str MERCY HOSPI)				r Location of Deat	h		ounty of Death	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir 08–29–1	th 942	9. Birthp Cour	place (State or Foreign mtry) MD
yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Loc	eation				1	10d. Inside City Limits
ne Mar 8a-f sl	Director	MD	BA	ALTIMO						1 Xes 2 No
with the		10e. Street and Number			10f. Zip Code			Ť	n of What Cour	ntry?
17215-UU36 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "Medical Examiner must be notified at	y Funeral	1 □ Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 ₩ No If Yes, Give	1	21206 Vas Decedent of H Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))- 14	USA . Race - Americ Black, White, pecify: BLA	etc.
Maryland 21215-UU36 d 2 should be filed within 72 hours af tht and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.	sted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa (Specify only highest grade	Year or Dates:	16a Deced	ent's Usual Occur	oation during most of wo d)	rkina		of Business/In	
ING 21215-U be filed within 72 h ttal Hygiene. d other than "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retire	d)		c	OPPIN S	STATE UNIV.
e filed al Hygid	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Su	ırname)	
arylar should be ind Ments marked umatic ev	2	HILTON BLOW		405 14-75-	- A I I (O		CLANTON		04-4- 7	- 0-1-1
re, Maryla s 1 and 2 should f Health and Mer tiem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type ALONZO CAIN, JR/HUS	<i>'</i>			and Number or R				o Code)
es 1 ar of Hea fitem ;		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of natory or other pla	i	Date	-	tion - City or To	own, State
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If item any Injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	HOL	LY HIL			8-2008			
Baltimo permit. Pag Department Important: I any Injury o once.		21 Signature Funeral Service Licensee	Worton			ENS ST.,				NS F.H., INC
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.							Approximate Interval Between Onset and Death
Physician	1	Immediate Cause (Final disease or condition resulting in death)		DVa	Tan	Luni	re			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	Due to (or as a consequ	ence of):						
60, %	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of)						
68760, 4 ficate be executed physician and is the burial-transit	edical E	d.								
		IF FEMALE:								-
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rdS, F. quires that in signed by	É	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the ur	iderlying cause gi	ven in Part I.		tobacco use	_	the cause of death? bably 4 □Unknown
UNVISION OF VITAI RECORDS, or Attending Physician: The law requires tafter death. Director: After this certificate has been signe in by the funeral director, page 2 should be c	Completed						24a. Was auto perl 1∐ Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 ☐ No
VITAL F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		_ lou	her:	ath (Check only			
VISION OF VITA Attending Physician: r death. ector. After this certifics by the funeral director, i	۲: ا	1 Yes 2 Ho 7.5	28a. Date of Injury	ER/Outpatien 28b. Time of	COLDON	4 🗆 Nursing	Home 5 ☐ Res 28d. Describe			ify)
arding Part.	atior	Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		rk?]Yes 2 □ No				
DIVISION Attendent after deat Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office			(Street and own, State)	Number or Rur	ral Route Number,
Hospita 4 hours Funeral tely filled	edical C		ician: To the best of my knower: On the basis of examinat and manner stated.							
To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier			29c. Licen			29d. Date	signed (Month,	, Day, Year)
		I had Ilmi	MP		D	40854			1/12/5	400 %
1/2		30. Name and address of person who cor	1	23a) (Type,	St Pa-1	PI	Balte	400	212	02
Sta Registr		31. Date filed (Month, Day, Year) JAN 15 20	32. Registrar's Signat	ture	St Parl					

1 - For State Begistrar

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			- negistiai								eg. 110,		
	Physici	an	1. Decedent's Nam	e (First, Middle,	*					2. Date of Dea Month		Year	3. Time of Death
	/Medic				John R. Cra	awford	, Jr.			Ja	n 13, 20	308	10:18 RM
) ·	Examin		4a. Facility Name (i	If not institution,	give street and number)			4b. City, Town, o	r Location of Death	1	4c. Cou	unty of Deat	
E				1280 S	ugar Maple Dr.				Marriottsvill	le		H	oward
	Funeral		5. Social Security N			e (In yrs. last	birthday)		If Under 24 Hrs.	8. Date of Birth	Voorl		hplace (State or Foreign
	Director		220-72-	1430	1 x M 2□ F	47	Yrs.	Months Days	Hours Min.		9, 1960	00	ountry)
			Usual Residence of					<u></u>					Marylan
	show show		10a. State	10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Man)	jo	MD		Howard				Mouniatta	11-			1 □ Yes 2 □ No
	the 28a-	Director	10e. Street and Nu					10f. Zip Code	Marriottsvi		On Citizen	of What Co	untry?
	Mith ber										-9		S.A.
	s 23	ral		ar Maple D		11.0	140.1	M - D	21104		114		ricen Indian,
	er de	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13.	Was Decedent of H f Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	14.	Black, White	
20	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by F		nied 2 Marrie	If Yes, Give	NO		1 ☐ Yes 2 ☐ No	Specify:		Spi	ecify:	
15-0036	ural'	d b	3 Widowed		Year or Dates:					Т			/hite
ភ	be filed within 72 hatal Hygiene. dother than "natuevent, the Medical	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)	1	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind o	of Business/	Industry
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7	yd w /gier er th	Ö					_	Ele	ctrician				ruction
פ	be filed Ital Hygi of other event, t	Be (17. Father's Name	(First, Middle, L	ast)				18. Mother's Nan	ne (First, Middle,	Maiden Sur	name)	
<u>0</u>		To I			John R. Crawf	ord Sr.				Jo	-Ann I	ackor	
Maryland	2 should and Men Is marke aumatic		19a. Informant's N	ame/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru				Zip Code)
Š	nd 2 allth a 27 is		John R. C	rawford, S	•		120	Cuman Man	In Dr. Manus	. 44			
o,	the He		20a. Method of Dis		1.	20b. Place	e of Dispo) Sugar Map sition (<i>Name of</i> matory or other place	ie Dr. Marrio	Date Date			Town, State
<u>ੋ</u>	g = 5		1 ☐ Burial 2	Cremation	B □Removal from State	cem	etery, crer	natory or other plac	ce)			- 7	
altimore,				5 ☐ Other (Sp		1	Bayvie	w Crematory	Jan	14, 2008		_Baltin	ore, MD
ā	permit. Departr Importa any init		21. Signature of Fi	and VIX	VIO	1 15 5	()	2. Name and Addre					
מ			Mu	XILIX	omplications that caused	1400	43	Slack Fu	neral Home,	P.A.	- 400 0	4040	
			23a. Part1. Enter	the disease, or control	omplications that caused	the death. [o not ent	er the mode of dyir	ng, such as cardiac	or respiratory ari	est,	1043	Approximate Interval Between
	Dhysisian		Immediate Cause	(Final	MI	-	7,	DESIA	000	PA 10	60		Onset end Death
	Physician /Medical		disease or condition resulting in death)	on		37/1	1	MOUNT	car	CANAC	75/		34
	Examiner			- 1	Due to (or as	a consequen	ce oi):					:	0
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	D #	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Due to (or as	a consequen	ce oi):						
	and nd trans	am	Cause (Disease or that initiated events resulting in death)	S 1 oot	с								
Ď,	an a		resulting in death)	Last	Due to (or as	a consequen	ce of):						
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X Q	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	an/Medical	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome	pf pregnancy	/	Te			23d.	. Date of del	livery
ň	atte atte	cia	in the past 12 1 ☐ Yes 2	months?	1 □Live birth 4 □ Pregnant at	2 ∐ Fetal de time of deat	eath 3∟ h 5⊑	Ectopic pregnancy Other (specify)	<i>y</i>			Month	Day Year
oj.	the c	Physici	9 ☐ Unknowr		9□Unknown								
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Š,	ires sign	by								1 □ Y	es 2□N	lo 3□Pr	robably 4 Unknown
ecord	requ	Completed								, ,			
ပ္		ed l								24a. Was a autop	in 2	4b. Were au	utopsy findings available completion of cause of
r	The ate has bage	E								perfor	med? 2D No	death?	2 □ No
VITal		Be C	25. Was case refe	rred to medical					26. Place of Dea	ath (Check only or			
>	Physiclan: this certific		examiner?	MO	Hospital: 1 ☐ Inpatie	ent 2□FR	/Outpatier	t 3 DOA Oth	or:	lome 5 Resid		Other (Spe	ciful
Ö	Phy r this ral o	<u>ا:</u>	27. Manner of Dea	th	28a. Date of Inju	ry 28	b. Time o			28d. Describe h			City)
	ding I. Afte fune	<u>[</u>	1 Vatural	5 ☐ Pending investiga	(Month, Day	y Year)	Injury		k? Yes 2□No		, ,		
S	tten death ttor: the	cat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could no	t he	In At homo	form of		103 2 110	005	44		
DIVISION	or Ai fter c irec n by	Certification:	4 Homicide	determin	ed building, et	c. (Specify)	, latili, Sti	eet, factory, office		City or Tow	treet and N n, State)	umber or Hi	ural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. Withe Funeral Director: After this completely filled in by the funeral directors.												
	losp t hou une	cal	29a. Certifier (Check only	1 CertifyIng 2 Medical F	Physician: To the best xaminer: On the basis o	of my knowle f examination	dge, deat	n occurred at the till vestigation, in my o	me, date and place	e, and due to the our	ause(s) and	d manner as	s stated. e to the cause(s)
	in 24 he F he F plete	edical	one)		and manner sta				, ,			, and dde	
	Within To t	ž	29b. Signature and	title of certifier				29c. Licens	e number	2	29d. Date si	gned (Mont	th, Day, Year)
ì			Date	4xto	^			D3	1172		Jana	~ 11	t. 2000
/			30 Name and add	ress of nerson 14	ho completed cause of d	eath (Item 23	la) (Tyne	Print)	0	1 (10,0	X	12-00
Ĭ-)		1/1 0	150	10700 CAA	OL (15)	1 An	200	Corumb	in Mr	21	1346	L
	Sta	to	31. Date filed (Mor	oth, Day, Year)	, ,	ar's Signature	1 +01/			· · · · · · · · · · · · · · · · · · ·		(
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			State of I	Maryland / Dep <i>Ce</i>	artment of H			ene 0	8 (00596
			Decedent's Name (First, Middle, Last)				2. Date of Death	_	Voss	3. Time of Death
	Physicia		Frances Harman Dexter				January	4 2	800	5:45 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	ar)	4b. City, Town, or	Location of Death		4c. County	of Death	
			5015 Morningstar Drive		-	rton		Но	ward	
	Funeral			Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, April 25	Year)	9. Birthp	lace (State or Foreign try)
	Director		212-20-1914	77 Yrs.			April 25	,1930	Mary.	Land
	pur *	1	Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or L	ocation				11	Od. Inside City Limits
	hanyli •ho	ក	Maryland Howard	Dayton						1 ☐ Yes 2 XNo
	the A	ect	10e. Street and Number	Daycon	10f. Zip Code		10	g. Citizen of V	What Coun	itry?
	with a or	ā	5015 Morningstar Drive	!	210	36		U.S.A		
	death with the Maryland me 23a or 28a-f ehow ir must be notified at	Funeral Directo	11 Marital Status 12. Was Decede		Was Decedent of H		ecify Yes or No-		e - Americ	
0	r Itar	표	1 Never Married 2 Married 1 ☐ Yes 2				Hican, etc.)		ck, White,	etc.
3-003p	filed within 72 hours after Hygiene. ither then "netural", or Ita int, the M. dical Examina	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date	s:	1 ☐ Yes 2 🖾 No	Specify:		Specify	Wh	ite
ה ה	72 hg	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	durina most of work		6b. Kind of Bu	usiness/Ind	dustry
7	ithin	ם	Elementary/Secondary (0-12) College (1-4) 5+	or 5+)	DO NOT use retired	d)		Baltim	ore C	City Schools
7	e filed within al Hygiene. I other then "			PII	ncipal	19 Mothar's Nam	e (First, Middle, M			tcy benoets
ב	be fi	Be	17. Father's Name (First, Middle, Last) Carroll Harman				Wheatle		10)	
Ĕ	2 should be and Mental le marked of raumatic ev	P	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address (Street				State Zio	(Code)
Maryland	d 2 sl th and 7 le r traur		John E. Dexter (Husband	- 91	Mornings					,
	as 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I filem 27 is marked other than "netural", or itams 23a or 28a-1 show it cither traumatic event, the Madical Examinar must be notified at		20a. Method of Disposition					Oc. Location -		own, State
ıtımore,	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ Removal from State Uponation 5 □ Other (Specify)	te Trinity	osition (Name of ematory or other place Episcopal	(9)	0000			
	글 문란금 .			Church C	emetery itzke run			len ar	el, Pia	ryland
g	Depa Impo eny I		MSK. Halen		555 Twin	Knolls Ro	ad Colu	mbia,	MD 21	045
			23a. Part 1. Enter the disease, or complications that cau	sed the death. Do not en						Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on eac Immediate Cause (Final	etastatic	hide	12 0 has	00 84VC	DMG		Onset and Death
	/Medical		disease or condition resulting in death) Due to (or	as a consequence of):	11/2/01 0	A C. O. C.	Do 301.C.	D1 (0)		
	Examiner									
		ner		as a consequence of):						
9.	nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
, 60,	ate be executed hysicien and fhe burial-transit	Ä	resulting in death) Last Due to (or	as a consequence of):						
20	physic physic s the b	dlcal	d							
o ×	death certificate e attending phys d for use as fhe	Physician/Med	IF FEMALE: 23c. If yes, outco	me of pregnancy				234 0	ite of delive	env
žog	atten for us	lan	in the past 12 months?	n 2 ∐ Fetaldeath 3	☐Ectopic pregnancy ☐ Other (specify)	/			onth	Day Year
o.		yslo	1 ☐ Yes 25 No 9 ☐ Unknown 9 ☐ Unknown							
<u> </u>	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to deal	h but not resulting in the	underlying cause grv	ven in Part I.	23e. Did tob	acco use con	tribute to the	he cause of death?
Records,	quires n sign	d by					1 □ Ye	s 2010	3 ☐ Prob	oably 4 Unknown
င္ပ	w requir s been si should	Completed					24a. Was ar	n 24b.	Were auto	opsy findings available impletion of cause of
Ä	The lav	mo tmo					autopsy perform	ned?	death?	2DNo
<u>ra</u>		a)	25. Was case referred to medical			26. Place of Dea	th (Check only one			
of Vital	ysici is cel direc	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ER/Outpatie	ent 3 DOA Oth	ner: 4 🗌 Nursing H	ome 5 🗖 Áeside	nce 6 🗆 Oth	ner (Specif	(y)
0	Attending Physician: Ir death. ector: After this certific by the funeral director,		27. Manner of Peath 28a. Date of (Month,	Injury 28b. Time Day Year) Injury	of 28c. Injur	ry al rk?	28d. Describe ho	w injury occur	rred	
<u> </u>	endir sath. or: Al	atle	2 Accident investigation			Yes 2 No				
Division	or Att	Certification;	determined 288. Place 0	Injury - At home, farm, s , etc. (Specify)	treet, factory, office		28f. Location (Sti City or Town	reet and Num. n, State)	ber or Hura	al Route Number,
	urs a		29a. Certifier 1 Certifying Physician: To the b	and and any legacided and and and	11	me data and place	and due to the or	ouso(s) and m	20007.25.5	etated
	Hospitel 24 hours a Funeral i	Medical	29a. Certifier 1 ☐ Certifying Physician: To the b (Check only 2 ☐ Medical Examiner: On the bas one) and manne	s of examination and/or i						
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		29c. Licens	se number	25	9d. Date signe	ed (Month,	Day, Year)
	- > - 0		Dand S. Pttonce	Attinda	01 017	7-07		•	01	04 2008
			30. Name and address of person who completed cause	of death (Item 23a) (Type	e, Print)	11 1		1.4		Tien
	12		DAVIDS, ETTINGER MI	D Johas	HOP/GN	S HOSPI	6 6	altin	ADRE	WY)
	Sta		31. Date filed (Month, Day, Year) _ 32. Rec	istrar's Signature	-6-0	·				
	Registi	ar	IAN 15 2008	Calling of the	COOLE!					

			For	State of Marylar	id / Dep	artment of H	lealth and	d Mental Hyg	giene			
			State Registrar		Ce	rtificate of	Death	F	Reg. No	008	0059	7
14 S	ge ge		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ath —	Year	3. Time of Death	
	Physicia /Medic	_	John 1	H. Dayney				January		2008	2:55 A	М
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of De	ath	4c. 0	County of Death		
			8615 Fluttering				enton			Anne Ar		
	Funeral			S. Sex 7. Age (In yrs.	last birthday, Yrs.	Months Days	If Under 24 H Hours Mi	in. (Month, Day	, Year)	Coui	lace (State or Fore	ign
L.	Director		367-20-2727	82	TIS.			Aug 16,	192	5 Mi	higan	
	w	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation	J. J			1	0d. Inside City Lim	its
	Aaryli f sho ed al	ō	Marriland Anna	Arundo 1		Odonton					1XYes 2□	10
	the N 28a-i notifi	Director	Maryland Anne	Arundel		Odenton 10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	with a or t be		8615 Fluttering	Loof Troil Uni	t 105		113		Un	ited Sta	tes	
	ns 23 mus	Funeral	11. Marital Status	12. Was Decedent Ever in U				(Specify Yes or No- lerto Rican, etc.)		4. Race - Americ	an Indian,	-
^	r iter	Ē	1 ☐ Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 🛣 No				ierto Hican, etc.)		Bleck, White,	etc.	
2	urs a al", o Exan	δ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:			Specify: WI	nite	
2-003e	72 ho natur ical	ted	15. Decedent's (Specify only highest		16a. Dece	edent's Usual Occup	ation during most of v	vorkina I	16b. Kin	d of Business/In	dustry	
Ž	thin 7 e. an "r Med	aple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)					
7	ed will rgien er th	Completed		1	Ins	tructor				Roller S	Skating	
and	tal Hy	Be (17. Father's Name (First, Middle, L.	ast)				Name (First, Middle,		,		
<u>X</u>	Ment Ment arked atic e	2	John Henry Da	ayney, Sr.			Alic			Fox		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi			•		Rural Route Numbe		•		
≥	and ealth m 27		Barbara Dayney/				ng Leaf	Trail Un		05 Odent		13
ore	Jes 1		20a. Method of Disposition 1X Burial 2 □ Cremation		cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20C. L00	ation - City of 1	own, State	
Saitimor	Pag ment ant: ury o		4 □ Donation 5 □ Other (Sp.	ecify) Me.	adowri	dge Mem P	ark 1/	14/2008			Maryland_	
žali	permit. Depart Import any Inj once.		21. Signature of Funeral Service L	cepsee	3	2. Name and Addre Donaldson	ss of Facility Funera	1 Home &	Crem	atory, 1	P.A.	
_	205 20	- 117	Juanita (X	Thomas	1	411 Annap	<u>olis Ro</u>	ad Odent	on,	Maryland	1 21113	
			23a. Part1. Inter the disease, or conshock, or heart failure. List of	omplications that caused the dea nly one cause on each line.	th. Do not er	nter the mode of dyi	ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	_a Acute Ren	al Fai	1ure				1		
	/Medical Examiner		resulting in death)	Due to (or as a consec								
	Examine	_	Sequentially list conditions,	b. <u>Cirrhosis</u>		ver						
	be sit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec								
	and rtran	хаг	that initiated events resulting in death) Last	c. Alcohol A								
3/0C,	cate be executed ohysician and the burial-transit	E		200 10 (0) 00 00 100	400.000							
	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	·	d								
٥ ×	leath certifica attending ph I for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome pf pregr	iancv				,	3d. Date of deliv	90/	
gox	atten for ut	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	☐Ectopic pregnand ☐ Other (specify) _	у		1	Month Month	Day Year	
j	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	dean o							
7.	w requires that the de been signed by the should be detached		Part II. Other significant condition	ns contributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to	he cause of death?	,
ďS,	sign d be	d by						1 🗆	Yes 2[XNo 3 ☐ Pro	bably 4 □Unkno	wn
Vital Record	v requ	Completed						24a. Was	an	24h Were aut	opsy findings availa	ble
ě	ne lav has je 2 :	пр						— autor	psy ormed?	prior to co	impletion of cause	of
<u></u>								1□ Yes	2X No	1 ☐ Yes	2	
=	Physician: The latticate the transfer of the certificate the rail director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	3500	t all par Oti	or:	Death (Check only o				
ō	Phys this	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatie	SIIL 3 DOA	4 LI Nursin	28d. Describe		Other (Spec.	<i>ty)</i>	
	ding f	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury		rk?]Yes 2 □ No			,		
<u>S</u>	Attending Physician: or death. ector: After this certification by the funeral director,	ical	3 Suicide 6 Could no	ot be 28e Place of injury - At h	l nome, farm, s			28f. Location (Street and	d Number or Rui	al Route Number,	
DIVISION	after Dire	Certification:	4 ☐ Homicide determin	building, etc. (Spec	ify)			City or To	wn, State,)		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1X CertifyIng	Physician: To the best of my kr	owledge, dea	ath occurred at the t	ime, date and p	lace, and due to the	cause(s)	and manner as	stated.	
	e Ho 24 h e Fur etely	Medical	(Check only 2 Medical E	xeminer: On the basis of examir and manner stated.	ation and/or	investigation, in my	opinion, death o	occurred at the time,	date and	place, and due	to the cause(s)	
	ompl	Me	29b. Signature and title of dentifier			29c. Licen	se number		29d. Dat	e signed (Month	, Day, Year)	
ł	L > L 0		1 AVV	alme	MD		D53910)	Ja	nuary 1	L, 2008	
	IT		30. Name and address of person v	who completed cause of death (Ite	1	e, Print)						
	10		Anurag Mahesaw				et, RM4	26 Balti	more	, Maryla	and 21205	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign		P						
				200	1. 1	7 69 6						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 13, 2008 Cheryl R. Dougherty 5:21 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2810 Glen Elyn Way Baldwin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, May 24, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1951 Hours 1 M 2 F Maryland 213-60-3165 Director 56 Usual Residence of Decedent the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 □ Yes 2 No Funeral Director Baldwin Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō 2810 Glen Elyn Way 21013 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status "natural", or item Black, White, etc. Yes 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Substitute Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I tem 27 is marked of В. Ripken Ruth Μ. Manlove Wesley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dougherty (husband) 2810 Glen Elyn Way, Baldwin, Maryland 21013 C. Michael 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 01/17/2008 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 Donation 5 Dother (Specify) Dulaney Valley Mem. Grợn. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 48005 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, € Due to (or as a consequence of): Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy 1∏ Yes 25. Was case referred to medical examiner?
1 Yes No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature of title of certifier 29d. Date signed (Month, Day, Year) 860 12 Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar 56

32 Registrar's Signatu

08-00277

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tobert Desmond		State of Maryland / Department of Health and Mental Hygiene - For State - For State - Certificate of Death - Reg. No. 2008 0059
Physician Medical Examine	1/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 2.155 hrs
viedicai Examine		Robert John Desmond January 9, 2008 January 9, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		8832 Walther Blvd Parkville Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min. 0.7 1.6 1.017
Director	L	113-12-7107 1X M 2 F 90 Yrs.
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show any d at once.	ا ة	MD Baltimore Parkville 1 Yes 2 X No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho aric event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 8820 Walther Blvd., #4113 10f. Zip Code 21234 10g. Citizen of What Country? USA
eath with Items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after dal", or	by F	3 Wildowed 4 Divorced If Yes, Give Year 1045 1 Yes 2 X No specify: Specify: White
hours 'natur Exami		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
hin 72 he. than tedical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Insurance Agent Insurance
15-0036 filed within 72 hours al Hygiene. d dother than "natural of other than "natural".	ទី	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)
21215-0036 Montal Hygiene marked other than event, the Medica	å	Harry Desmond Elizabeth Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 nd 2 shoul alth and N m 27 is m aumatic	٥	Dorothy Desmond/Wife 8820 Walther Blvd., #4113, Parkville, MD 21234
4 5 5 5 E		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Cremation - City or Town, State Garrison For Est 1-17-08 Owings Mills, MD
Baltimore permit. Pages 1 Department of 1 Important: If injury or other	+	4 Donation 5 Other Specify: Veterans Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home Inc.
iii ii ga	3	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204
Physician /Medical	20	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
aminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
		Sequentially list conditions,
	<u> </u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.
vecuted	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
O, e be exec	edical	UNPENDED AMENDED
3760 ficate l g phys	\$	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 68766 e death certificate the attending phy ed for use as the b	틶	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
BO) the death y the att	Physician/N	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.O. res that the signed by be detach		Diabetes mellitus 1 Yes 2 No 3 Probably 4 Vunknown
rds, require been si	Completed by	24a. Was an autopsy findings available prior to completion of cause of
eco he law ite has	팂	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rec	ညို ရှိ	25. Was case referred to medical 26.Place of Death (Check only one)
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director.		examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: Scene
n of laing Ph. h. After t		27. Manner of Death 28a. Date of Injury 1 ✓ Natural 5 Pending 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 ✓ Yes 2 No
isio	icat 	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division spiral or Attentours after death reral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) or Town, State)
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
T w io	¥ ¥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		(a(uuy)) O.C.M.E. January 11, 2008
3×1		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta		31. Date filed (Month, Day, Year) 10 1 2008 32. Registrar's Signature.
Registr	ŒЦ	JAN 1

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

o, 1124 Mace
32. Registrar's Signature

o completed cause of death (Item 23a) (Type, Prin

Avenue, Butmore, MD 21221

D0061907

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per 1h 98/6 2-14-08 vt. State of Maryland / Department of Health and Mental Hygiene 006U I Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:00AM 29 anuare 14,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N 00 70m Calver 75 a If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security N3873 Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs last birthday, **Funeral** Days Months 1 M 2 M€ Yrs Director March Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No mai Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number vedere 1125 Z 12 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masters Sistain th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIMME lore ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name Relationship (Type. Print) God Son Balto Are 21212 Health ind, 20b. Place of Disposition (Name of gemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I 1 Rurial 2 □ Cremation 4 □ Donation 5 □ Other (5 3 ☐Removal from State 1-22-2008 censbaro, N.C. 5 ☐ Other (Specify) June / I Service Lice 22. Name and Address of acility sacto, md, 21229 , march the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, feart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enti-shock, or Immediate Cause (Final embolis unemonth Physician ue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown uctive Domonary Completed 24a. Was an autopsy performed? 1☐ Yes 2 No Were autopsy findings available prior to completion of cause of has page 2 death? 1 ☐ Yes certificate 2 ☐ No Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 2 No Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined or A 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1.X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cop ann Carolo Miller 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Bethy

			1- For State of Maryland / Dep	artment of Health and Martificate of Death		iene 008	00602
a.		н	Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death
H	Physicia /Medic		Jane N. Campbell Emich		Month Januar	Ty 14 2008	8:30 A. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		X	134 Cockeysville Road	Cockeysville If Under 1 Year If Under 24 Hrs.	8, Date of Birth	Baltimore	
я	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 212–20–3679 85 Yrs.	Months Days Hours Min.	(Month, Day, June 9	, Year) Cou	nplace (State or Foreign untry)
- 2	aleskilen den Epa		Usual Residence of Decedent		June 9,	, 1922 part	., Maryland
	nyland how Lat		10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	ne Ma 8a-f s atifiec	Director		ysville			1 □Yes 🎗 🖸 No
	with the		10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Co. United Sta	tes
	ns 23	Funeral	134 Cockeysville Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	21030 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	of America	ican Indian,
0	after o		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White	
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:			hite
<u>2</u>	"natu	lete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		16b. Kind of Business/l	ndustry
12	filed withir Hygiene. other than ent, the Me	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	ecretary		Veneer Man	ufacturing
2	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, i	Maiden Surname)	
/lar	uld be Menta Irked Itic ev	To B	Walter C. Norris	Gert	cude H.	Ambrose	
lar	ages 1 and 2 should be filed went of Health and Mental Hygier tt: If Item 27 Is marked other tt y or other traumatic event, the			ling Address <i>(Street and Number or Rur</i> 35 Walters Lane Sp			
و ف	ss 1 and 2 of Health a litem 27 Is r other trau	0. 9	20a. Method of Disposition 20b. Place of Dis			20c. Location - City or	
nor	Pages nent of int: If its iry or o		t⊟Burial 2 □Cremation 3 □Removal from State	ematory or other place) Methodist Janua	ary 17,	•	ey, Maryland
Baltimore, Maryland 21215-0036	permit. Page Department (Important: If any injury or once.			netery 2008 22. Name and Address of Facility 22. Alternative			
ñ	Der Imp any		Meleto Blh.	aceful Alternative 2325 York Road T	'imonium	, Maryland	21093
			23a. Part1. Inter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a. Dementia				7 years
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				/
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ansit A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhin Cause (Disease or injury that initiated events				
oʻ	an an	Exa	resulting in death) Last Due to (or as a consequence of):				_
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and ragge 2 should be detached for use as the burial-transit	dical	d				
9 ×	leath certific attending p I for use as I	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	luon.
Box	leath c atten	Physician/Med	235. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	t the d by the ached	hysi	9 Unknown 9 Unknown				
	w requires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	
ord	equire sen siç ould b		Hypertension		1 🗆 Y	es 2□No 3□Pr	obably 4 Unknown
Vital Records,	ne law r has be ge 2 sh	Completed	Type 2 Diabetes Mellitus		24a. Was a autop	sy prior to d	topsy findings available completion of cause of
ä	: The icate l		(perfor 1∐ Yes	med? death? 2 No 1 ☐ Yes	2□ No
	Physician: The la r this certificate has ral director, page 2	Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑, No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	26. Place of Deat			-46.4
ō	y Phy er this	: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ence 6 Other (Specow injury occurred	city)
0	arth. rr: Afte	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Division or	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Run, State)	ural Route Number,
	oital ours aff		Constitution Physician To the best of my benefician described		and due to the	(-)	atata d
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 29a. Certifier 1人人Certifying Physician: To the best of my knowledge, de 2□ Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within To the	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mont	h, Day, Year)
)			I af a MO	057444	7	Jan 15	, 2008
	30		30. Name and address of person who completed cause of death (Item 23a) (Typ Hlexander W Chen, MO	PO Box 19099, T	owson, 1	10 2128	4
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		/		
	Registr	ar	JAN 1 5 2008 22 280 65 A	361			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month_ Physician : 05 PM Jan 2008 /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** Glen Burnie 8. Date of Birth (Month, Day, Year) March 24,1929 If Under 1 Year | If Under 24 Hrs. Sex 1/2X M 2□F Birthplace (State or Foreign Country) **Funeral** Days Hours 78 219-22-1257 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No must be notified Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 418 Rogers Avenue 21060 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis W. Ehlers Hattie I. Gill Department of Health and Men Important: If Item 27 is marke any injury or other traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4472 Birdsong Way Las Vegas, Nevada 89147 Ms. Elaine Frazier/ Daughter Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 18 1 X Burial 2 ☐ Cremation 3 Removal from State Maryland Vets Cem. 2008 Crownsville, MD (Specify) 21. Signature rvice Licensee 22. Name and Address of Facility Singleton Funeral & Cremation MOIYII Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RESPILATON /Medical Due to (or as a consequence of): Examiner PERIDAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit GANGA ENOUS Due to (or as a consequence of): Box 68760, 51-707°C Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes, 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0053703

Registrar DHMH 17 Rev 1/2001 BALOMONE

31. Date filed (Month, Day, Year)

MUDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Berhane Tsion

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 00604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:07 John 2008 January 1.3 **/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mercy Hospital Baltimore 6. Sex 115 M 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 217-09-1525 Months Hours Yrs Director 5/30/1920 D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Southampton Road 21014 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Automobile Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Watson Edwards Hattie May Barker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Myfvanwy Fdwards / Wife 20a. Method of Disposition 907 Southampton Road, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ott tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 1-18-08 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Oy 2015 Immediate Cause (Final leta V **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the Division or Vital Records, P.O. 9 Unknown 9 Unknown veral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No autopsy perform 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

To the Hospital within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

Nomas 31. Date filed (Month, Day, Year)

> 1 5

29a. Certifier

Pau

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and manner stated

301

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

			State of Maryland / Department of Health and Mental Hygiene 1- For State April 1975 1/15/09 TT Certificate of Death Page N2 0 0 8 0 0 6	05
			1- State Registrar Amend #8, perFH,g875, 1/15/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of	Death
	Physic		Ann Elizabeth Frey San (1 2008 /0.2	20AM
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			Genesis Loule Raven Baltimore Baltimore	
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. If Under 24 Hrs. 8. Date of Birth 1/12/1935 Birthplace (State of Month, Day, Team (Month, Day, Team)	Foreign
0	Director		Usual Residence ol Decedent	<u> </u>
2	ryland how		10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit	
17	ith the Marylan or 28a-f show	cto	MD. Datimore 100 Kyling	24.10
~	death with the Maryland ms 23a or 28a-f show croust be notified at	Funeral Director		3
1	Jeath The 23	erai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	3
3	after death w	Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	
29	1215-0036 within 72 hours after death with the Maryla ene. then "neturel", or items 23s or 28s-f shot then "neturel", or items 23s or 28s-f shot fre Maryled Examinating the motified at	d by	3 Widowed 4 Divorced Year or Dates:	•
2	15-in 72 in 72 in 15-in	lete	(Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)	
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No.	nd had had all hygher all hygher had other heart.	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
2	Maryland 2121: 12 should be filed within h and Mental Hygiene. 7 is marked other then " ireumatic event, fre Me.	၉	19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
V	Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other treumatic event, the Mane.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	34
F	s 1 and 2 if Health a litem 27 is other train		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
	Pages Pent of Int: If it		4 Donation 5 Other (Specify) Druid Ridge Cemetery 1/15/2008 Baltimore, MD	
	Baltimore, permit. Pages 1 a Department of Hes Important: If Item any injury or othe once.		21. Si prature of fruneral Service Licensee 22. Na de and Address of Ficility Evans Funeral Chapel and Cremation Service Servi	2
	m goesa		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation and the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	ie i
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Which is a specific or condition. Which is a specific or cause on each line. Which is a specific or cause or each line.	
	Physician /Medical		disease or condition resulting in dealth) Due to (or as-a consequence of):	
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	V 8 5	luer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
	xecute and al-tran	Examiner	resulting in death) Last Oue to (or as a consequence of):	
	8760, Keste be executed by sicien and the burial-transit	cai E	d	
	68 rtificet	Aedi	IF FEMALE:	
	Box 6 eath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Festal death 3 □ Ectopic pregnancy Month Day	Year
	P.O. In the dead of the a letached if	by Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
	P.O.	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of contribute to t	death?
	cords, requires been sign should be			Unknown
	eco law re es bee	Completed	24a. Was an autopsy performed? 24b. Were autopsy findings prior to completion of codeath?	available cause ol
	The The page	Con	performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No	
	Vital Fician: The certificete	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
	on of Vital Reding Physician: The h. After this certificate he funeral director, page	7; To	20d Describe how injury occurred	
	vitending death.	atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
	Division of Vital Records, I or Attending Physician: The law requires that after death. Director: After this certificate hes been signed in by the funeral director, page 2 should be to	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Suicide 8 ☐ Suicide 9 ☐ Could not be determined 8 ☐ Suicide 9 ☐ Could not be determined 1 ☐ Could not be determined 1 ☐ Could not be determined 1 ☐ Could not be determined 1 ☐ Could not be determined 28 ☐ Could not be determined 1 ☐ Could not be determined 28 ☐ Could not be determined 1 ☐ Could not be determined 28 ☐ Co	nber,
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	• Hos 24 hc • Fun letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (and manner slated.	s)
	To th within To th comp	₩.		
	(1		Mu. Attending physician US3642 Jun 13 200	
	P		29b. Signature and bitle of certailer 29c. Elemise families 29c. E	704
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	Pny /IV Exa	lec
ox 68760,67	n certificate be executed	ending physician and
ox 6	h certifi	ending

Division or Vital Records, P.O. Bo

WILLIAM FLANNERY

		Please Type or Print State of Man		delible Ink. Ensure A artment of Health and	-	_	
		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	rtificate of Death	2. Date of Death		3. Time of Death
Physicia /Medic		William Edward Flanner	y, Jr.		January	11, 2008	12:34Р м
Examin		4a. Facility Name (If not institution, give street and number) Stella Maris		4b. City, Town, or Location of Deat Timonium	h	4c. County of Deat	
Funeral	- #s	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.			hplace (State or Foreign
Director		212-52-6700 The sidence of Decedent	5 Yrs.	Worlding Days Trouts William	08/01/19	152 Ma	ryĺand
yland now at		10a. State 10b. County 1	0c. City, Town or Lo				10d. Inside City Limits
ne Mar 8a-fsl	Director	Maryland Harford	Ab	ingdon	10	g. Citizen of What Co	1 ☐ Yes 2 X No
with the Sa or 2		10e. Street and Number 203 Yellowbrick Court		10f. Zip Code 21009	10	U.S.A.	undy:
ems 2:	Funeral	11. Marital Status 12. Was Decedent Every Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
s after	by Fu	1 ☐ Never Married 2 Married I ☐ Yes 2 Mo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specify:		Specify:	White
2 hour	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	rkina 1	6b. Kind of Business	Industry
vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wo DO NOT use retired) Ems Operator		as & Elect	ric Company
filed v Hygie other 1	Be Co	17. Father's Name (First, Middle, Last)	0,300	18. Mother's Na	me (First, Middle, M		,, <u>, , , , , , , , , , , , , , , , , ,</u>
Menta Menta arked atic ev	To B	William Edward Flannery, Sr.			Schafer		
d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street and Number or F</i> Yellowbrick Court			
s 1 and of Healt		Norma Flannery - Wife 20a. Method of Disposition		psition (Name of matory or other place)		20c. Location - City or	
Page ment o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gardens d	of Faith Cem. 01/	1		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Vicensee Reples & Munic.	Le	2. Name and Address of Facility Conard J. Ruck, I	nc. Bal		Road Iryland 21214
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on part the immediate Cause (Final	death. Do not ent	ter the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		disease of condition resulting in death)	consequence of):				
Examiner			30,1004001100 01,7				
ed .	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	consequence of):				
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The law requires that the death certificate rate has been signed by the attending physi page 2 should be detached for use as the I	hysician/Medical	IF FEMALE: 23c. If yes, outcome pf		-		23d. Date of de	livery
death	siciar	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at til		□Ectopic pregnancy □ Other (specify)		Month	Day Year
hat the d by th	Phys	9 Unknown	not esulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
quires t n signe	d by	Part II. the significant ditions contributing to death but	60114		1 □ Ye	s 2 No 3 P	robably 4 X Unknown
law rec as bee 2 shou	Completed				24a. Was ar autops	y prior to	utopsy findings available completion of cause of
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Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	2 ☐ ER/Outpatie	Othor	eath <i>(Check only one</i> Home 5 Reside	nce 6 XIOther (Spe	ecify) HOSPICE
ng Phy (fter thi		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Cay)	Year) 28b. Time o	Work?	28d. Describe ho	w injury occurred	
ttendi death. ctor: A , the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury	/ - At home, farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location (Str	reet and Number or F	lural Route Number,
tal or A s after al Dire	Certification:	4 ☐ Homicide determined building, etc.			City or Town		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state and manner state	examination and/or ir	th occurred at the time, date and pla- nvestigation, in my opinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	is stated. ie to the cause(s)
To the within To the comple	Med	29b. Signature and title of centurer		29c. License number	5 29	9d. Date signed (Mon	nth, Day, Year)
		30. Name and address of person who completed cause of dea	ath (item 23a) (Type,	, Print)		/ /	
(4)	•	DR. EDDIE NAKHUDA 2300 DULA 31. Date filed (Month, Day, Year) 32 Registrar	- C:		MD 21093		
Sta Registr		IAN 1 5 2008	s Signature				
		O 8 11 0 1	20				

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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Rural R	loute Numi				Zip Code)	
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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			FOI	partment of Health and N ertificate of Death	Reg	ene j. No. 2 () () 8	00609
	Physicia		Decedent's Name (First, Middle, Last) STEPHEN MICHAEL FURY		2. Date of Death Month JANUARY	14, 2008 Year	3. Time of Death 7:53 A. M
	/Medic Éxamin	race:	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
* E.			GILCHRIST CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	TOWSON If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMO	
	Funeral Director		218-70-7133 1XM 2 F 51 Yrs	Months Days Hours Min.	(Month, Day, 1 12/16/19	956 MAR	place (State or Foreign intry) YLAND
	show show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 [XNo
	the Ma 28a-f	Director	MD BALTIMORE REIST	ERSTOWN 10f. Zip Code	100	g. Citizen of What Cou	
	3a or	I Dir	11919 TARRAGON ROAD UNIT A	21136		USA	
	death	Funeral		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
2-003p	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Consider	ITE
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7 0	illed Hygid Sther ent, tl	BeCo	12.TH GRADE 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
<u>a</u>	uld be Mental rked o	To B	JOSEPH H. FURY	MARIE A	A. ZITO		
Maryland	2 should be and Menta is marked raumatic ev		, , , , , , , , , , , , , , , , , , , ,	ailing Address (Street and Number or Ru	ral Route Number,	City or Town, State, Z	
	1 and Health Health Her tr					TOWSON, MD	
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Baitimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Livensee		HE JOHNSON	N FUNERAL	
r			23a/Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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ř		Com			perform	ed? death?	2□ No
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0	nding tth. r: Afte e fune	ation:	1 ☐Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Certificati	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
_	pital o	Se	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	, and due to the ca	use(s) and manner as	stated.
	ne Hos ne Fun e Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	h, Day, Year)
-			for they lity, and	025205		Imumy 1	1,0008
	10		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) Charles St. Hal	to md	20206	
	Sta	ate	31. Date filed (Month, Day, Year) #32. Registrar's Signature	white sir view	-10 /		
	Regist		JAN 1 5 2008				

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		For State		State of	Marylar		partment of F ertificate of			-	giene Reg. No	000	0	00610	
	¥	Registrar Decedent's Name	e (First, Middl	le, Last)				Dou		2. Date of De	ath	4.00	0	3. Time of Death	
Physicia /Medic		CHRI	STINE			FRAN	QUEMONT			JANUARY	Y 1	-		5:22 A ^M	
Examin				n, give street and num	ber)		4b. City, Town, o		of Death			. County of [
Funeral		5. Social Security N		RINTH ROAD 6. Sex 7	. Age (In yrs.	last birthda	BALTIMO if Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir	+h	BALTIM 9.	Birthpla	ice (State or Foreign	
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w		Usual Residence of 10a. State	Decedent 10b. County	,	10c. Ci	ty, Town or	Location						10	d. Inside City Limits	
Maryll -f sho ifed at	tor	MD	BAL	TIMORE	BA	ALTIMO	RE							1 □Yes 2 No	
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iter de	Funeral	 Marital Status Never Marri 	ied 2□ Mar	12. Was Deced Armed Ford	es?	J.S. 1	3. Was Decedent of H If Yes, specify Cub	lispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.))-		4. Race - American Indian, Black, White, etc.		
urs af al', or Exami	δ	3 X Widowed		If Yes, Give			1 ☐ Yes 2 ☐ No	Specify	<i>/</i> :			Specify:	WHI	TE	
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205 20		100	20	10/		\geq	8900 REIS				-	<u>ESVIL</u>		MD 21208	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filed in by the funeral director, page 2 should be detached for use as the	ledical	(Check only one)		I Examiner: On the ba and mann		ation and/oi				rred at the time					
To To	Σ	29b. Signature and	title of certific	er .			29c. Licens					ate signed (#			
11		30 Name and addr	ress of person	who completed cause	of death (Ite	m 23a) /Tvn	e. Print)	~	1		Jan	vary 1	4,3	and 21215	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ,2008 Marian Κ. Fridas January 3:00a 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Essex If Under 1 Year | If Under 24 Hrs. Riverview Nursing Center <u>Baltimore Co.</u> 8. Date of Birth (Month, Day, Year) 3 – 28 – 1935 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🖸 F Maryland 215-30-7724 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 No MD Baltimore Co. Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 3112 Liberty Parkway USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Haas Edward Henry Kistner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liberty Parkway Dundalk, MD 21222 <u> Athanasios Fridas-Husband</u> 3112 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery | 1-14-08 |Baltimore, MD 4 Donation 5 Other (Specify 22. Name and Address of FacilityKaczorowski Funeral Home, PA 21. Signature of Funeral S vice Licens 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or 17ch line. Preumonia Immediate Cause (Final disease or condition resulting in death) consequence of): Due to (or as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Year cause of death? 4 Unknown sy findings available pletion of cause of

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

Il Hygiene.

permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the

Director

Funeral

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Completed

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

ng physician and as the burial-transit ate has been signed by the attending physician page 2 should be detached for use as the buria certificate

The law requires that the death certificate be executed

Division or Vital Records. P.O. Box 68760.

Examiner Completed by Physician/Medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be P

Certification:

Medical

29a. Certifier

resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause
	- -	24a. Was an autopsy performed′	
25. Was case referred to medical	26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)

27. Manner of Death

1 X Natural 5 Pending 2 Accident 3 ☐ Suicide

investigation 6 ☐ Could not be 4 Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 □ Yes 2 □ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

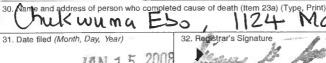
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier

D0061907

29d. Date signed (Month, Day, Year) 2008

MD 2122

State Registrar 31. Date filed (Month, Day, Year)



Mace Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** emmino 7:10 PM 2008 /Medical 4b. City. Town, or Location of Death County of Death 4a. Facility Name (If not institution), give street and number **Examiner** 761 pita 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** 1 M 2 □ F Hours Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

n 27 is marked other than "ratural", or items 23a or 28a-f show her frau matter than 25 or 28a-f show her fraumatic event, the Medical Examiner must be notified at 10c. Cita Town or Location 10b. County ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Completed by Funeral 14. Race - American Indian Black, White, etc. 11. Marital Status orces? 1965
2 No 1965
ive Dates: 1969 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry kind of work done during most of working DO NOT use retired) dongery (0-12) College (1-4or 5+) Be ၉ emouiles Ja. Informant's Name lationship (Type. Print) ural Route Number. City n. State. Zin Code permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other once. 206) Place of Disposition cemetery, cremator 20a. Method of Disposition 1 Burial 3 Removal from State 2 ☐ Cremation 4□Donation 5 Other (Specify) 21. Signature of Funeral Service 23a. Part1. Enter the disease, or com shock, or heart failure. List only aused the death. Do not enter the mode f dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): astrointestina years /Medical Examiner Esophageal varices Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine years Cirrhosi the burial-trar requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician years Physician/Medical Hepatitis as ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4☐Pregnant et time of death 1 ☐ Yes 9☐Unknown 9 🗌 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 2 No Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient Certification: To 1 ☐ Yes 2 ☐ № 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) To the Hc within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT 2438946 . O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

18

31. Date filed (Month, Day,

un

Year)

32. Hagistrar's Signature

Union

Memorial

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death **Physician** 45PM 2008 noug /Medical or Location of Death 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Day Year) Home If Under 24 Hrs Hours Min. last birthday) If Under 1 Year **Funeral** Months Days Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Yes 2 □ No the Medical Examiner must be notified Completed by Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code tvenue or items 23a Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 ☐ I Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. use retired, Elementary/Secondary (0-12) College (1-4or 5+) dth other traumatic event, ner's Name (First, Middle, Cast) To Be ould be fi Mental F n and Mental Pages 1 and 2 should 19b. Mailing Address (Street and Number or Ru Town, State, Zip Code, Department of Health a Important: If Item 27 Is any injury or other trainonce. MD 21133 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 toleno lancimoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): .O. Box 68760, physician Physician/Medical the use as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ate has b autopsy perform certificate 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 1 🔲 Inpatient this funeral 27. Marrier of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural (Month, Day 5 ☐ Pending investigation after death. 1 Tes 2 🗌 No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signajure and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Would 32 Registrar's Signature

rom Woods Road.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otato or maryia	Ce	rtificate of	Death	R	eg. No. 2	108	00614		
	Physicia	an	1. Decedent's Name (First, Middle,	ŕ				Date of Dea Month	th y 13,20	Year	3. Time of Death		
	/Medic			Sally Ann		Gracey		Januar			6:43 P M		
	Examin	er	4a. Facility Name (If not institution,				r Location of Death Oundalk			y of Death 1 t. imo:	re Co.		
_	· ·		2110 Merritt B 5. Social Security Number		s. last birthday)			8. Date of Birth			place (State or Foreign		
	Funeral Director		213-34-6542 Usual Residence of Decedent	1□M 2√2 F 70	Yrs.	Months Days	Hours Min.	(Month, Day	(Month, Day, Year) Country) March 9,1937 Pennsylvania				
	land bw		10a. State 10b. County	10c. C	City, Town or Lo	ocation				1	10d. Inside City Limits		
	Mary -f she fied a	tor	Maryland Bal	timore				Dundalk	:		1 ☐ Yes 2 No		
	h the or 28a	Director	10e. Street and Number			10f, Zip Code		1	0g. Citizen of	What Cour	ntry?		
	th wit		2110 Merritt	Blvd.		21222	2		United	Stat	es		
	r dea lems er mi	Funeral	11. Maritai Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ack, White,			
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1∐Yes 2¥∑No	Specify:		Specia	fy:	White		
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Ē	shoul nd Me mark	Ţ	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street	and Number or Run	al Route Numbe	r, City or Town	ı, State, Zip	Code)		
Š	alth a		Mrs. Grace Cos	ner (Daughter) 681	4 5th Ave	e. Dunda	lk, Mary	land	21222			
Ę,	of He		20a. Method of Disposition		. Place of Dispo	osition (Name of ematory or other place	ce) ;	Date	20c. Location	- City or To	own, State		
Ĕ	Page ment o		MXBurial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Spe	ecify) H	olly Hi	ll Mem. (Edns. $1/3$	16/2008	Middl	e Riv	er, MD		
Dallillor	permit. Departr Importa any inje		21. Signal No. of Funeral Service Li	censee) 2	2. Name and Addre Duda-Ruch 7022 Wise	ss of Facility K Funeral Ave. Du	Home of	Dunda	lk, I	nc. 1222		
۲		-	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the de	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between		
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C	The ate hg	mo:						perfor 1□ Yes	med? 2 ☑ No	death?	2 □ No		
VICE	ctor,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	ne)				
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	ling F After unera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occu	rred			
SICI	ttend death stor:	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 290 Place of Injuny . At	home farm st		Yes 2 □No	28f Location /S	treet and Num	her or Rur	al Route Number,		
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_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and the funeral director, page 2 and the funeral director.		29a. Certifier 1 1 Certifying	Physician: To the best of my k	nowledge, dea	th occurred at the ti	me, date and place,	and due to the o	ause(s) and n	nanner as s	stated.		
	ne Ho n 24 h ne Fui	Medical	(Check only 2 ☐ Medical E	xaminer: On the basis of exami and manner stated.	ination and/or i	nvestigation, in my	opinion, death occur	red at the time, o	date and place	, and due t	o the cause(s)		
	To th within To th comp	Me	29b. Signature and the of certifier	$\Lambda \cap$		29c. Licens		2	29d. Date sign	ed (Month,	Day, Year)		
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	8		David Madder,			Lva. Suite	e ZOO Bal.	timore,	maryıa	11a 2	1236		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		and)							

			For State Registrar	State of Ma		artment of He rtificate of De			ené. UUO g. No.	00013
	Physici /Medic		1. Decedent's Name (First, Middle, Las ROBERT LOUI	•				2. Date of Death Month Jan.	Pay, Year 20	3. Time of Death 08 6:50 a.M
	Examir		4a. Facility Name (If not institution, give Rock Spring Villa			4b. City, Town, or Lo Fores	ocation of Death St Hill		4c. County of Dea	
	Funeral Director		5. Social Security Number 212-22-2345 6. Security Number 11	7. Ag 7 M 2□ F	e (In yrs. last birthday, 81 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth OCt. 9,	9. Bi 1926 Ma	rthplace (State or Foreign country) ryland
	70	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		10c. City, Town or L	ocation est Hill				10d. Inside City Limits 1 ☐ Yes 2√2 No
	h with the 23a or 28s st be not	al Director	10e. Street and Number 1227 Bonaire R	oad		10f. Zip Code 21050		10	g. Citizen of What C	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If items 23a or 28a-1 show if item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2√2 No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	I within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(ife.	edent's Usual Occupation of work done dur DO NOT use retired)		sing	6b. Kind of Busines: Manufacti	•
land 2	ould be filed Mental Hygi arkad othar atic evant, I	To Be C	17. Father's Name (First, Middle, Last) Harry H. Gunther	•			8. Mother's Nam	e (First, Middle, M. 1ma Hoey		
, Mary	and 2 should salth and Men n 27 is marks ier traumatic		19a. Informant's Name/Relationship (7 Robert H. Eagan	_{урв, Print)} Nephew		ing Address <i>(Street and</i> 27 Bonaire				
Baltimore,	Pages 1 anneal of He		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Specify			osition (Name of matory or other place) Memorial			oc. Location - City o	
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lices		2	2. Name and Address 6500				.H. Inc. and 21212
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne.	iter the mode of dying,		or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	ficate be executed a physician and st the burial-transit au	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of): a consequence of):	nian	1'alaya			year
.O. Box 68	ne death certification the attending the dor use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of de Month	elivery Day Year
<u>α</u>	w requires that the been signed by should be detact	by	Part II. Other significant conditions of	entributing to death b	ut not resulting in the u	underlying cause given	in Part I.		acco use contribute	to the cause of death? Probably 4 Unknown
al Reco	to the	Completed	cororan artin		grathing			24a. Was an autopsy perform 1 Yes 2	ed? prior to	autopsy findings available completion of cause of s 2 \(\square\) No
Division of Vital Records,	To the Hospital or Attanding Physician: I within 24 hours after death. To tha Funaral Director: After this certificat completely filled in by the funeral director, p	lon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 S Natural 5 ☐ Pending	Hospital: 1 Inpatie		of 28c. Injury at Work?	4 Nursing Ho	th (Check only one ome 5 Residen 28d. Describe how	nce 6 Other (Sp	ecity) ASST Living
Divisio	il or Attanding after death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)		s 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 ★ Certifying Phyone 2 ★ Medical Example	ysician: To the best iner: On the basis of and manner sta	f examination and/or in	th occurred at the time, nvestigation, in my opin	date and place, ion, death occur	and due to the cau red at the time, dat	use(s) and manner a te and place, and du	as stated. se to the cause(s)
)	To t To ti	W	29b. Signature and title of certifier	Merry	MM	29c. License n	2925		d. Date signed (Mor	
	6			chre in	eath (Item 23a) (Type	Print) Max M	1/10	mel 1	Pin Mn	21014
	Sta Registr		31. Date filod (Month, Day, Year)	Degistr	ar's Signature	with)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** agen enuar ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
der 1 Year | If Under 24 Hrs. Baltimore Rehabilitation Extended Care 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Pay Year) Months Hours 1∭ M 2□ F VA Director 231-30-4902 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 □ Yes 2√□ No MD Baltimore Director Gwynn Oak 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be r 7419 Remoor Road by Funeral 21207 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∑Yes 2 No If Yes, Give 1945–47 Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 ☐No Specify: African-American altimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Technican Westinghouse 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mason Washington Sr. ဂ Rebecca A. Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary O. Graham/Wife 7419 Remoor Road, Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If iter any injury or oth I ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Fint on Dinent Woodlawn Cemetery 1-19-08 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Sign ture of Furferal Service Ligersee andon 9200 Liberty Rd., Randallstown, MD 21133 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. ediate Cause (Final asse or condition End Stage Renal Disease) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deaty? Be Completed by vostate ancer 2 ☐ No 3 ☐ Probably 4 Donknown 1 ☐ Yes cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed (es 2 1□ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Mann of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 L Natural Injury s after dea... 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luch Raven Boulevard, Battimore

32, Registrar's Signature

ZU08

Katherine Gil

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Katherine Bauer

Gill

Division of Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8820 Walther Blvd. # 4128 Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) Mary and 5. S24-G-07-19231 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 □ F 87 Yrs. Director Usual Residence of Decedent parmit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiena. Important: If filem 27 is marked other than "natural" --- any injury or other traumetic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XX Funeral Director Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. # 4128 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 📉 No f Yes, Give 1 ☐ Yes 2 Ho Specify: Completed by Specify: White 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (John Bauer Katherine Corbin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) Barbara McClean (daughter) 3930 St. Paul Rd., Manchester MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdn. 1/15/08 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Furface Licensee 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner ie to for es a consequence of): Chrunic Obstructive Lung Disease Physiclan/Medical Examiner Hospital or Attending Physician: The law requiras that tha daath certificate ba axecuted for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Ś Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 WIL 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) မှ 1 Yes 2 ₽.No 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Director: After to in by the funera 5 Pending investigation 1 ☑Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely fillad in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H 0052365 January 11, 2008 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 10 se or death (Item 230) (Type, Print)
20.0. 8800 Walther Boulevard, Parkville Maryland 21234 Jeffreys 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend items 5, 19a/ per artines 575 Health and Mental Hygiene

Certificate of Death

Reg. No.

II, 2008

3. Time of Death

5:15 AM

2. Date of Death

January

DHMH 16 Rev 6/95

			1 □ Yes 2 □	No 3 Probably 4 Unknow
			24a. Was an autopsy performed? 1 Yes 2 M No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 1 No
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3[□ DOA Other: 4□ Nursing Ho	ome 5 Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	280 Place of injury At home farm street for	actory, office		Struck by Vehicle Number or Rural Houte Number,
	nysician: To the best of my knowledge, death occurrence: On the basis of examination and/or investigand manner stated.			
29b. Signature and title of certifier	1) lh. w	29c. License number	29d. Date	e signed (Month, Day, Year)

GrEENE

St. Balfimore, MD 21201

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatui

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Hollyoak 12, 2008 Katharine 20:33 P M January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk Genesis Eldercare - Heritage Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 215-01-2184 Director 98 April 22,1909 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛛 No Dundalk Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 238 USA 21222 7529 Westfield Road Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ Specify:White 1 ☐ Yes 2X No þ 3 Widowed 4 □ Divorced other than "natural", Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keypunch Operator Steel 12 years permit. Pages 1 and 2 should be life Depertment of Health and Mental Hy Important: If Item 27 is marked oth any light or other traumatic event pose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Thompson George W. Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7529 Westfield Road, Dundalk, Maryland Merrilee Johnson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 16, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLÉROTIC CARDIOVAS CULAR DISEASE **Physician** /Medical Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed CANCER Due to (or as a consequence of) ANEMIA Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 IZNo Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Dunknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Beath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 s after deam.
ral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 PNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funeral C 1 (Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number

State Registrar

Box 68760.

Ö

Division of Vital Records, P.

death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2008 10, 7:24 P Betty Louise Harden January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🕅 F 212-48-8439 Director 20, 1945 Maryland 62 Dec. Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford Maryland Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 313 Philadelphia Road "natural", or items 23a 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ⚠ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 U.S. Government Data Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be 2 Paul Francis Harden Agnes Viola Corns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Peggy J. Harden / Sister 313 Philadelphia Rd., Joppa, MD 21085 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Christian Chu Cem: 1-15-08 Joppa, Maryland 21. Sign tu pof Fure al Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PEA Failure Physician Heart disease or condition resulting in death) Due to (or a: a consequence of): /Medical Examiner spiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pra Ventriculac Tachycardia the burial-tra Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pulmonary 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Cardiac certificale Arrhythmia HardenBeth 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? ne Hospital or Attending PI n 24 hours after death. ne Funeral Director; After the pletely filled in by the funeral 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) D0036487 January 11, 2008 ss of person who completed cause of death (Item 23a) (Type, Print) M.D. 500 Upper Chesapake Dr. Bel Air, MD 2-1014 Registra's Signature 30. Nime and add Bentman, M.U. 500,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Month, Day, Year)

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:50 A 13, 2008 January Bernard Calvin Harkins /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **X**M 2 ☐ F 220-30-0928 5, 1931 Maryland Director 76 Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Forest Hill Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3019 Grier Nursery Road USA 21050 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Dairy Farm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Paul Wilson Harkins Olla (nmn) Kirk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3019 Grier Nursery Road, Forest Hill, MD 21050 Martha Lee Grafton / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deer Creek UMC Cem. 1-16-08 Forest Hill, Maryland 21. Signature & Funeral Service Lice 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** days neumonl disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2√ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Abatural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide

MODOIN Records, law requires The Vital 0 or Attending Fafter death. Division Director: the Funeral

should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural", or Items 23a or 28a-f show

Pages 1 and 2 s nent of Health an

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

riffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 North J (6/1 32. Registrar's Signature

State Registrar

State Registrar DHMH 17 Rev 1/2001 Eagtern

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miller

		•	For State Registrar		State of Ma	aryland / Dep <i>Ce</i>	artment of H rtificate of		-	giene Reg. No. /	2008	0062			
- 8	Physici /Medic		1. Decedent's Name (#	First, Middle, Last)	R		HURWIT	Z	2. Date of De Month	Day	, 2008	3. Time of Death 2: 27 P	М		
	Examir		4a. Facility Name (If no UNION ME	EMORIAL H	IOSPITAL		4b. City, Town, o	or Location of Death		4c. C	ounty of Death	/A			
	Funeral Director		5. Social Security Num 219-40-67	757 1 ¹	7. Ag	e (In yrs. last birthday, 70 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05/03/	y, Year)	9. Birth Coa	nplace (State or Forei untry) MD	gn		
	faryland show ed at		Usual Residence of De 10a. State 10	Ob. County		10c. City, Town or L	ocation					10d. Inside City Limit			
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980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	by Funeral	11. Marital Status1 X Never Married3 Widowed 4 [2 Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No 13.	was Decedent of r If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecily fes of No Rican, etc.)		Black, White				
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d 2	2 should be filed and Mental Hygi is marked other aumatic event, t	Be C	17. Father's Name (Fin	rst, Middle, Last)			OLLINI	18. Mother's Nam	e (First, Middle,	Maiden S	urname)				
/lan	should be fand Mental I	To B	BENJAMIN	١		MORDECH	I P	SARAH				BANK			
Maryland	ind 2 sho alth and 1 27 is ma er trauma				*	I							_		
Baltimore,	Pages 1 a ent of He- nt: If item ry or othe		20a. Method of Dispos	ARC HURWITZ / NEPHEW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1777 REISTERSTOWN RD., SUITE 135 EAST, INTERPRETATION REPORT OF Commentary or other place) 1 M Burial 2 Cremation 3 Removal from State Commentary or other place) 1 M Burial 2 Cremation 5 Other (Specify) 1 Condition 5 Other (Specify) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 1 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 2 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 2 Date Condition - City or Town, State, 190, Name of Commentary or Other place) 2 Date Condition - City or Town, State, 190, Name of Commentary or Other place, 190											
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	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart f. Immediate Cause (Fin disease or condition resulting in death)	allure. List only or	Due to (or as	tic Si a consequence of):	rock	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death 4 don's			
8760, 🕿 📗	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, but it is a consequence of the consequen										*		
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/ita	cian: ertific	Be (25. Was case referred examiner?	. –	I 14 - 14 - 14 - 14 - 14 - 14 - 14			26. Place of Deat	th (Check only o	one)			_		
or Vital	Physician: this certific ral director,	2	1 ☐ Yes 2 No. 27. Manner of Death) [lospital: 1 Inpatie			4 LI Nursing Ho	ome 5 Resi			cify)			
Division	I or Attending Ph after death. Director: After thi I in by the funeral i	Certification:	1 ☑ Natural 2 ☐ Accident	5 Pending investigation 6 Could not be determined	(Month, Da	Year) Injury	M 1□	rk? Yes 2 No		Street and		ıral Route Number,			
Ω	Hospital 4 hours a uneral ely filled	edical Cer	29a. Certifier 19 (Check only one)	☑ Certifying Phys ☐ Medical Examí	sician: To the best	of my knowledge, dea f examination and/or i	th occurred at the t	ime, date and place opinion, death occu	, and due to the	cause(s)	and manner as place, and due	stated. to the cause(s)			
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and titl	e of certifier			29c. Licens	se number		29d. Date	signed (Monti	n, Day, Year)			

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinay Jagadeeska, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Union Memorial Hospital, MD Constitute of

AT2438946 January 11, 2008

68760,
P.O. Box
Records,
or Vital
Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 700 PM Januar Michael George Iwashko 2008 10 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner at Baltimore N/A Hospital Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 12/9/1986 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1**☑** M 2□ F Marvland 218-13-7685 21 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No MD Baltimore Timonium Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2210 Eastlake Road 21093 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify: Specify. þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Student Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marta M. Tatchyn George J. Iwashko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Eastlake Road Timonium, Maryland 21093 Marta M. Iwashko / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/19/2008 St. Michael's Cem. Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, Maryland 21. Signature of Funeral Service Licensee Melilia Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 days Due to (or as a consequence of): Physician /Medical Examiner Due to (or as a consequence of): Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-tra Due to (or as a consequence of) attending physician for use as the burial pe IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo 24a. Was an autopsy performed? certificate 1 Yes Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific January 10,2008 WD 10 30. Name and address of person w (Item 23a) (Type, Print) Hospital 2401 West Belvadore Avenue maybe MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland /		rtment of He tificate of D		Mental Hy	/giene Reg. Ne	21111X	00625
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	eath 11	ay Year	3. Time of Death
	Physici /Medic		Elizabeth Jones		·		th Oit Tana	Landing of Dooth	1		2008	8:26 A M
	Examin	er	4a. Facility Name (If not institution, given Atlantic General				4b. City, Town, or Berlin	Location of Death	1		Worceste	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last l	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi			place (State or Foreign
	Director		217-20-2292	□ M 2 / CXF	78	Yrs.	Months Days	riours iviiri.	11720	7192	9	MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Maryl	ţō	MD Worcest	er	Berli	n						1 ☐ Yes 2XXNo
	r 288	iec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
	th with	Funeral Director	11647 Beauchamp F	Rd.			21811				USA	
	ar dea	uner	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ameri Black, White	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Modical Examiner must be multified.	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10	1	□Yes 2 No	Specify:			Specify: W	hite
음	2 hou	ted	15. Decedent's Ed	ducation	16	a. Deced	ent's Usual Occupa	tion		16b. l	Kind of Business/Ir	ndustry
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Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailin	g Address (Street a			ber, City	or Town, State, Zi	p Code)
S	nd 2 salth ar		William Jones / h			1164	7 Beaucha	mp Rd.,	Berlin	, MD	21811	
e.	of Hei		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place	of Dispo	sition (Name of natory or other place	9)	Date	20c. I	Location - City or T	own, State
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Baltimore, Maryland 21215-0036	ermit. Separti nport ny inj		21. Signature Juneral Prvice	Xee X		22 I	. Name and Addres Ouda-Ruck	s of Facility Funeral	Home o	f Du	ındalk, I	nc.
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2 O. P.	law requires that the as been signed by th	Phy	Part II. Other significant conditions	contributing to death b	ut not resultin	in the u	nderlying cause give	en in Part I.	23e, Did	I tobacco	use contribute to	the cause of death?
Dr. B	signe d be d	d by	Turin, Sind digitinosin sononio	John Daniel Grand		9 111 110 41	naony mg sacco gree				105	obably 4 Unknown
	w requ	Completed							24a. Wa	is an	24b. Were au	topsy findings available
Janes al Reco		d Ho								opsy formed?	prior to o death?	ompletion of cause of
ر ا	iician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of De	-	-	10 103	213110
- 0	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie			t 3□ DOA Othe	4 🗀 Nursing i	·		6 □Other (Spec	city)
7300	sing Phys	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year) 28i	Injury	Work		28d. Describe	a how inj	jury occurred	
12abi 126 Divisio	Attending r death.	icat	2 Accident investigatio 3 Suicide 6 Could not b	OB Disease the	ury - At home	farm str	eet, factory, office	Yes 2 □ No	28f. Location	(Street	and Number or Ru	ral Route Number,
112 0iv	after Dire	Certification:	4 Homicide determined	building, et	c. (Specify)				City or T	own, Sta	ite)	
My	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Pl	hysicien: To the best miner: On the basis o	of my knowled	dge, deat	occurred at the tim	ne, date and place	e, and due to th	e cause	(s) and manner as	stated.
	the Hin 24 the Fi	Medicai	one)	and manner sta	ated.	and or in			u.100 at [110 [1110			
	To Too	-	29b. Signature and title of certifler	1			29c. License	140	5	250. L	Date signed (Manti	S
			30/Name and address of person tho	completed cause of o	leath (Item 23	d) (tvoe	Print),	0 -	7	1	11/0	01011
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	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		-0-					0
	Regist	rar	JAN 1 5	2008 A	S. 200 9	M.	(mile)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3 Jabaji N. Laila /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ros edale Franklin Baltimore Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 💢 F 69 March 25,1938 Palestine Director 242-63-9799 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 💆 No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene. Important: I fire 27 is marked other than "natural", or items 23a or any filury or other traumatic event, the Medical Examiner must be a rany filury or other traumatic event, the Medical Examiner must be a USA 21237 5324 Litany Lane, apt. B Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryfand 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education 12 n/a Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zareefa Shafeeka ပ Salim Rizkallah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5324 Litany Lane, Baltimore, Hatim N. Jabaji/Son Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/15/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Timonium, Maryland Dulaney Valley Mem. Fungel Servic, Li 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Timonium, Maryland 21093 23a. Part1 Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause Final disease o condition resulting in Lain) Due to (or a la consequence of): **Physician** /Medical Acquired PneuMonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner n Fection Ecoli be executed Due to (or as a consequence of): and burial-tran Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 ponths? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2**1** No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

or Attending n 24 hours after death.
The Funeral Director: After the funeral physics of the funeral phys Hospital

State

Registrar

within 24

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

9000 Franklin Square Drive Baltimore, MD 21237 Jonathan enaknin

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 13, **Physician** 2008 11:15 PM Myrtle Justis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner College Manor Nursing Home Lutherville Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5/3/1923 9. Birthplace (State or Foreign Country) Virginia 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖫 F 216-46-3153 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Dogwood Lane 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juliuis Brandt Lovie Ellis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8703 Marburg Manor Drive Lutherville, MD 21093 Linda Gerner / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2008 Hilltop Serv. Corp. Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21204 York Road Towson, Home, Inc. 1050 Ruck Towson Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2415 disease or condition resulting in death) /Medical Due to (or as - nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform 2□ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760, To the Hospital

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

O 7

Medical

2 ☐ Accident

4 Homicide

(Check only one)

Alexa 31. Date filed (Month, Day, Year)

3□ Suicide

29a. Certifier

State

29b. Signature and	title of certific	er		1	
▶ (b)	MC	tanc	4	an	MI
				_	

5

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 00043937

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC 1-crada

32. Registrar's Signature:

Suite 5103 6701 NCLa

DHMH 17 Rev 1/2001

08-00181

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Luther M Johnson		r. St - For State	ate of Ma	ryland / I	Deparl <i>Certi</i>	tment of ficate of	Health Death	n and	Menta	ıl Hygi		Reg. No	. 21	101	2 0062
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	lle,Last)							2.	Date of Dea Month January	ath			fime of Death 0521 hrs
Medical Examin	ner	LUTHER M. J				14	b. City, To	wn, or Lo	ocation of		anuary	7, 200 4	c. County of De		
		Sinai Hospital	on, give street a	id namber,		}	Baltim	ore					N/A		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	t birthday)	If Under		If Under:	24Hrs. 8 Min.				oreign	L.
Director		204-05-2082	1XM 2	F	88	Yrs.					3-13	- 19	19	Countr	^{y)} MARYLAND
any	-	Usual Residence of Decedent 10a. State 10b. County		1	0c. City, T	own or Locati	on							l l	d. Inside City Limits
	اِ	PA. YOR	K		DEI	ĽΤΑ									Yes 2 No
Aarylar 28a-f ş	Director	10e. Street and Number					10f. Zip					10g. C	itizen of What	Country	?
death with the Maryland or items 23a or 28a-f show must be notified at once.		91 GREENS L		s Decedent E	Sugar in II C	13 Wa	1	7314	anic Origin	n? (Spec	ify Yes or N	No-	USA 14. Race - A	mericar	n Indian, Black,
ath wit items?	Funeral	11. Marital Status 1 Never Married 2	Married Arn	ned Forces?_	X No	If Y	es, specify	Cuban,	Mexican, I	Puerto Ri	can, etc.)		White, e	tc.	
fter de l'', or			ivorced If Yes, Gi	ve Year			Yes 2					148	Specify: I		
hours a natura Sxami	ed by	15. Decedent's Education (Sp	ecify only higher	st grade comp ege (1-4 or 5		16a. Deceder during m	nt's Usual (nost of worl	Dccupation of the second contract of the seco	on (Give ki DO NOT u	ind of wor use retired	rk done d)	160	. Kind of Busin	essimu	ustry
36 nin 72 than " dical I	plet	Elementary/Secondary (0-12 - 12 -	,	ege (1-4 01 3 0-	')	POS	STAL						GOVERN	IMEN	Т
5-0036 iled within 77 Hygiene. d other than	Completed	17. Father's Name (First, Midd	e, Last)					1			JOHNS		en Surname)		
2121! ould be fil Mental F marked ic event, i	Be c	CHARLES JOH 19a. Informant's Name/Relation		nt \		19b. Mailin	g Address	(Street					City or Town,	State, 2	ip Code)
MD 2 d 2 shoul lth and N n 27 is m	J.	LUTHER JOHN								D. B	ALTIM	ORE	, MARYI	LAND	21215
Te, N 1 and 1 1 Health Fitem		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 XRem	oval from Sta		Place of Disportenatory or of	sition (Nar ther place)	ne of cen	ľ		Date	- 1	c. Location - C		1
altimore, rmit. Pages 1 an epartment of Hea tportant: If ite		4 Donation 5 Other	Specify:		MT.	ZION					-2008		ELTA, I		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	ce Licenseul	LA	υ. ι										YLAND 2121
Physician	_	23a. art . Enter the disease,	or complications	that caused	the death.										Approximate Interval Between Onset and
xaminer	8	ail re. List only one cau Imm date Cause (Final disea	se a. Acute	subdural										- 8	Death
Adminer		or condition resulting in death) Due to (or as a conse	equence of	f):									
	Jer	Sequentially list conditions, if any, leading to immediate		or as a conse	equence of	f):									
	Examin	cause. Enter Underlying Cau (Disease or injury that initiated events resulting in death) Las	Due to	or as a conse	equence o	f):		_							
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- 2 o o i i	edical	UNPENDED		NDED	of pro-	nancu.							23d. Date of o	delivery	
: 6876C certificate ending phys	E	IF FEMALE: 23b. Was decedent pregnant i past 12 months?		If yes, outcor Live birth		2 F	etal death		Ectopi	c pregnar	ncy		Month	D	ay Year
Box 68760, e death certificate bo the attending physic ed for use as the bur	Physician/M	1 Yes 2 No 9	Unknown g	Pregnant at	time of de	eath 5 (Other (Spe	ecify)				- 1			
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ords w requas been should	plete										a	utopsy erform	ed? d	rior to co eath?	ompletion of cause of
Rec The la icate h	Completed							26 Plac	e of Death	(Check o		es 2	No 1	✓ Ye	s 2 No
Vital Pysician: ysician: his certifi	a a	25. Was case referred to med examiner?	Hospita	l: 1 Inpati	ent 2 🗸	ER/Outpatie	ent 3	DOA	Other ₄		g Home 5	i R	esidence 6	Other	
n of Vital Records, P.O. ding Physician: The law requires that the Affer this certificate has been signed by functed director, page 2 should be deased	-	27 Manner of Death	28	a. Date of Inj (Month, Day,	ury Year)	28b. Time o	of Injury	I	ury at Wor	_	28d. Desc Subject		w injury occurre	∌d	
	i i	1 Natural 5 F	renaing	an 7, 2008		FOUND: 0440 hrs			Yes 2		28f Locat	ion (Str	eet and Numbe	er or Ru	ral Route Number, City
Division pital or Attendii ours after death. ieral Director: #	Certification.	3 Suicide 6	Could not be	8e. Place of I Specify) Nլ		nome, farm, st	reet, lacto	ry, onice	bullarily, e		or To 4669 Fall	wn, Sta s Roa	te) d Room 329	Bed 1,	Baltimore, MD
Division of Vital To the Hospital or Attending Physician: within 24 hourst Birector. After this certif			g Physician: To Examiner: On th				curred at t	he time,	date and p	lace, and	I due to the	cause	(s) and manner	as state	ed. e cause(s)
To the within	Medical	one) 2 Medical	anui	e basis of exi	amination I.	and/or investi			nse numbe		at the time;		29d. Date sign	ed (Mo	nth, Day, Year)
	2	29b. Signature and title of ce	1	A	>	`			c.M.E.				January 7,	2008	
		30. Name and address of pe	rson who comple	eted cause of	death (Ite	m 23a)									
0		Zabiullah Ali, M.D.	Assistant	Medical E	Examine	er 111 P			ltimore,	MD 21					
Regi		a 31. Date filed (Month, Day, Y	ear) 2008	32 Registr	rar's Signa آنون الرواك	ture	aster	·			O	CME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00269 State of Maryland / Department of Health and Mental Hygiene 00629 George Thomas Juratovac Certificate of Death 1- For State Reg. No. 3. Time of Deat 2. Date of Death Decedent's Name (First, Middle,Last) Month Day January 9, 2008 Physician/ 1638 hrs Medical Examiner George Thomas Juratovac 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Havre de Grace 17 Walnut Street 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days Months MD 12-20-1955 Director 52 Yrs 214-70-8037 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location in y 10a. State Yes 2 X No 23a or 28a-f show notified at once. Joppa Harford Co. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21085 1010 Hanson Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: White 1 Yes 2 X No specify: If Yes. Give Year permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mortall Hygiens. Inportant: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner. Divorced Widowed 16b. Kind of Business/Industry ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) <u>Maryland Canvas</u> Technician Computer N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosalie 🗕 Zubrowski Be John Ronald Juratovac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 6509 Langsdale RD Rosalie Harris - Mother 20c. Location - City or Town, State Ξ Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 1-12-08 Baltimore, MD Bayview Crematory Other Specify: Donation 5 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License Avenue Baltimore. Dundalk Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Methadone and nordiazepam intoxication associated with Approximate Interval Between Onset and **Physician** Death **Tedical** oxycodone, hydrocodone and cocaine use Immediate Cause (Final disease **aminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED #18, perFH,0876 and Physician/Medical X UNPENDED attending physician or use as the burial perME 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown Completed by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? After this certificate has 2 No page 7 ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) director, 25. Was case referred to medical Division of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: 1 examiner? ER/Outpatient 3 Inpatient 2 ٥ 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Yes 2 y No Natural Pending Fnd 1/9/2008 Fnd 4:00 pm To the Funeral Director: completely filled in by the Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 17 Walnut St. Havre de Grace, MD 6 X Could not be 3 Suicide determined (Specify) mobile home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Winder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 10, 2008 O.C.M.E. 22 MO torsha 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

2008

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. R

strar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Kralick **Physician** 05:30 P LOUIS 0 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore VA Rehabiliation & Care Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days **X**□M 2□F 18, Maryland Director 212-28-3216 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes ঠ☐ No Director Baltimore Baltimore 10e. Street and Number 3308 Benson Avenue 10g. Citizen of What Country? 10f. Zip Code 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1942—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examinopare. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Gertrude Baranyi Henry P. Kralick, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8822 Warm Granite Dr. Columbia, MD 21045 Marian Payer - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 1-14-2008 Baltimore, MD 22. Name and Address of FacilitAm rose Funeral Home, Inc. Si Litur of Funer I S. Nice Licensee 1328 SUlphur Spring Rd., Arbutus, MD 21227 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician End Strene /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 | Junknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Hospital

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

within 24

A. MROWIEC 31. Date filed (Month, Day, Year)

homes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of sertifier

(Check only

3900 Lock Never 32. Registrar's Signature

and manner stated.

297809

29d. Date signed (Month, Day, Year)

01/10/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 State	State of Mary	yland /	Departm Certific			and M	-	_	2008	00	631
1	100		Registrar 1. Decedent's Name (First, Middle, Last)			OCTUTO	ate or i	Death		2. Date of De		2000	3. Time o	of Death
	Physicia		Lorrain	e Kir.	79					Jan.	Day		C120	
4	/Medic		4a. Facility Name (If not institution, give st		J	4b. (ity, Town, o	r Location o	of Death	-JCKI.	-	2008 County of Death		•
À	Examin	er	Union Memorial Ho					ltimo				-	/A	
	Funeral	-	5. Social Security Number 6. Sex		n yrs. last b		der 1 Year	If Under	24 Hrs.	8. Date of Bir	th		place (State intry)	or Foreign
ь	Director		212-30-1139	M XX F	75	Yrs. Mon	hs Days	Hours	Min.	(Month, Da			vland	
			Usual Residence of Decedent					4		3 03 1	,,,,	TAGE		
	how how		10a. State 10b. County	10	Dc. City, To	wn or Location							10d. Inside C	
	e Ma ta-f s	cto	Maryland N/A			Baltimo	re						TXXY es	2 □ No
	or 28	Directo	10e. Street and Number			10f	Zip Code				10g. Citiz	en of What Cou	*	
	23a ust b		3970 Edgehill Avenu						1211				USA	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral		Was Decedent Eve Armed Forces?	er in U.S.	13. Was D If Yes,	ecedent of H specify Cuba	lispanic Ori an, Mexicar	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.))- 1	 Race - Amer Black, White 		
36	s afte	by F	1 Never Married 2 Married	1 □ Yes 2 ☑ No If Yes, Give		1 □ Ye	s 2 /21/N o	Specify:				Specify:	white	
5-0036	hour tural'	o b	₩Widowed 4 Divorced	Year or Dates:	16	a. Decedent's	leual Occur	ation			16h Kin	nd of Business/I		
5	"na" edic	Completed	15. Decedent's Educa (Specify only highest grade	completed)		(Give kind o life. DO NO	work done	during mos	t of workir	ng	7.0	duction	. *	
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	be filed within 72 hours after death with the Marylan dal Hygiene. d athey than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle, Last)						er's Name	(First, Middle			9	
an		To Be	William Shipley]	Eliza	beth M	laise.	1		
Maryland	£ ₽ E E	-	19a. Informant's Name/Relationship (Type	e. Print)	19	9b. Mailing Add	ess (Street	and Numbe	er or Rura	l Route Numb	er, City or	Town, State, Z	ip Code)	
_	12 ha 7 is		Gilbert King, Jr.	Son	3	970 Edo	ehill	Ave.	Apt.	A3 Ba	ltim	ore, Mai	vland	21211
ē,	- ± 2 ±		20a. Method of Disposition			of Disposition of the control of the				ate		cation - City or		
9			1 ☐ Purial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		MD Ve	teran C	emeter		1/18/	2008	Owin	ngs Mil	ls. Ma	rvland
Baltimore,	permit. Page Department of Important: If any Injury or once,		21. Signal e Funeral Service License		Gar	rison F	orest	ss of Facilit	ly					7
ñ	Dep Imp any onc		Saw H Cu	Denter		Bur	gee-He	enss-S	Seitz	Funer	al Ho	ome, Ind	2.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	e death. De	not enter the	node of dyir	ng, such as	cardiac o	r respiratory a	rrest,	aryland	Approxima Interval Be	ite
	Physician		Immediate Cause (Final										Onset and	Death
1	/Medical		disease or condition resulting in death)	Due to (or as a c	onsequenc	vascu	wi		10112	gose	-			
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58760,	The law requires that the death certificate be executed the has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	edical	d.											
_	death certific attending pl	Me	IF FEMALE:											
ROX	ath c	ian	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf p 1☐Live birth 2 [Fetal dea		ic pregnancy	/			2	3d. Date of deli Month	very Day	Year
	ne de the a hed f	Physician/M	1 ☐ Yes 2 1 No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne of death	5 ☐ Othe	(specify)						,	
о. О	that the		Part II. Other significant conditions cont	ributing to death but n	not resulting	in the underlyi	na cause aiv	en in Part I		23e. Did	tobacco us	se contribute to	the cause of	death?
Vital Records,	w requires that the d been signed by the should be detached	i by	Breast cance	•		,	3]No 3∏Pro		/
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m										1□ Yes	2 No	1 ☐ Yes	2⊟No	
=	i cian : Th certificate ector, pag	Be	25. Was case referred to medical examiner?	ospital:			DOA Oth	or:		(Check only				
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ב	ling After funer	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Y		Injury	28c. Injur Wor	yaı k? Yes 2.⊟		28d. Describe	now injury	y occurred		
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Division	or A fifter of Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	iaiii, sireei, ia	nory, oance				wn, State)	d Number or Ru)	rai Houte ivui	mper,
_	To the Hospital or Attending Physician: within 42 hours dister death. To the Funeral Director: After this certified completely filled in by the funeral director, it	ت ت	29a. Certifier 1 Certifying Physi	cian: To the best of n	ny knowled	ge, death occu	red at the ti	me, date ar	nd place a	and due to the	cause(s)	and manner as	stated	
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examination one)		camination a									(s)
	orthin orthin	Me	29b. Signature and title of certifier				29c. Licens					e signed (Month		
	->- o		* Houn Pein	flon MD	_		DO	058	86	0	JA	N 9,	2008	
	/		30. Name and address of person who con		h (Item 23a) (Type, Print)						7		. ~
	り			DN, MD	3.	333 N.	CALV	ETIT	SF,	svite	222	BAL	10,14	0
ź	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		48							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryla		artment ertificate			d Mental Hy	giene Reg. No.	008	00632		
1/4			1. Decedent's Name (First, Middle, La	51)					2. Date of De Month	ath Day	Year	3. Time of Death		
	Physicia /Medic		DODEDM LEVIC RESCUENCE OD Januar							y 10,	2008 ounty of Death	3:50 P M		
la Parasi Parasi	Examin	Acres	45 City Town of						r Location of Death					
			Glen Meadows 5. Social Security Number 6. S	7 Age (In w	s. last birthday		n Arm	Under 24 I	Hrs. 8. Date of Bir		altimor			
	Funeral Director	1		× 2□F 76					Min. (Month, Da May 5,	ıy, Year)		nplace (State or Foreign untry) nington, DC		
1985	12		Usual Residence of Decedent						Indy J	1731	110001			
	nylan show		10a. State 10b. County	10c.	City, Town or L	ocation						10d. Inside City Limits 1 ☐ Yes 2X No		
	Ba-fs	Directo	Maryland Baltimore Glen Arm											
	with th	Dir	10e. Street and Number								n of What Co	untry !		
	a 23s	Funeral	11630 Glen Arm 1		Dad 21057 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec					US/	A Race - Amer	ncan Indian.		
	Iter d	L L	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1	0.0.	If Yes, speci	ify Cuban, I	Mexican, P	uerto Rican, etc.)		Black, White	e, etc.		
036	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f show the Madical Evacities must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2	2∰No S	Specify:		S	pecify: Wh	ite		
ည	72 ho natur licel	Completed	15. Decedent's E		(Giv	edent's Usual e kind of worl	k done duri	on ing most of	working	16b. Kind	of Business/I	ndustry		
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)			_ ·				
2	filed w Hygier other th		17. Father's Name (First, Middle, Last,	2	Pri	nter	18	3 Mother's	Name (First, Middle		ting			
anc	ntal h	Be	Harold Dale Kees						Bolton Pierce					
Maryland 21215-0036	should be filed within 72 hours after death with the Marylar and Mental Hyglene. In marked other than "natural", or liama 23a or 28a-f show matic event, the Maulical Examinar must be notified at	ဥ	19a. Informant's Name/Relationship (19b. Mailing Address (Street and Number or Rural Ro									
	~ ~ ~ ~		Viola K. Keeslin	/ Wife	22.69					n. Mai	Maryland 21057			
altimore,	ot Heelth of Heelth fitem 27		20a. Method of Disposition	200	p. Place of Disposition (Name of cemetery, crematory or other place) Date 21					20c. Loca	0c. Location - City or Town, State			
E	Pages nent of int: If it		4 Donation 5 Other (Specify) Hilltop Service Corp. 1-14							4-08 Towson, Maryland				
alt	permit. Page Department of Important: If any injury or once.	li	21. Signalure of Funeral Service Lice		1	22. Name and	d Address o	of Facility	Home, P.A	A _		The State of the S		
m —	205 20		Malelle	mes		1317 C	lokest	oury F	Road, Abir	adon.	Mary	and 21009		
			23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. A / / Onset and Death											
2,1	Physician		Immediate Cause (Final disease or condition resulting in death) a Viv gressive Dufra Nuclear Palsy											
	/Medical Examiner		Toolang in assum,	Due to (or as a cons	b to (or as a consequence of):									
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	b									
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Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy nant at time of death 5 ☐ Other (specify)					23	Bd. Date of del Month	Day Year		
<u>о</u> .	the de	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	n deam 5	_ Other (spe	өспу)							
	The law requires thet the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions	ause given	ven in Part I. 23e. Did tobacc			co use contribute to the cause of death?						
rds	quires n sign	D D	To perdension to the second se							1 Yes 2 No 3 Probably 4				
00	aw requir ss been si 2 should I	olete									24b. Were autopsy findings available prior to completion of cause of			
æ	The lay	E								ormed?	death?	2□ No		
ta	ician: Th certiticate rector, pag	BeC	25. Was case referred to medical examiner?				1		Death (Check only	one)				
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ū	ding Phys	-CO	27. Manner of Death 1 Natural 5 Pending		28a. Date of Injury (Month, Day Year) 28b. Time Injury			t • 2□No		28d. Describe how injury occurred				
Sic	Attending Physician: or death. ector: Atter this certitics by the funeral director. p	Icat	2 Accident investigation 3 Suicide 6 Could not be	De Disco of Injury A	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,				
Division of Vital Records,	after Direct Lin by	Certification:	4 Homicide determined	building, etc. (Sp.	ecify)	street, radiory	, 0.1100			own, State)				
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certiticate his completely tilled in by the funeral director, page	edical C	(Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exam	knowledge, dealination and/or	ath occurred investigation.	at the time,	date and p	place, and due to the	e cause(s) a	and manner as place, and due	s stated. e to the cause(s)		
	the Phin 24 the F	Medi	one)	and manner stated.	1		c. License n				signed (Mont			
	70 Wit		29b. Signature and title of certifier	MIXM)	1	120	122		AA A	11.10	08		
	V		70001	completed south of death (Itom 22a) (T	a Print)	730	127		0000	11) ~	VU		
1	5+1		30. Name and address of person who	MC (7) (N	CHALL	S 35	1 1	340711	MORE A	10 2	1204			
	Sta Regist		31. Date filed (Month, Day, Year)	34. Registrar's Si	gnature	aster.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1 2008 **Physician** 124/AM January BERNICE KURYK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sinai Hospital of Baltimore Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 0172671924 1 □ M 2 🖒 F 83 218-18-8689 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director OWINGS MILLS MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 21117 3420 ASSOCIATED WAY, UNIT 311 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL SERVICES SOCIAL WORKER permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If Item 27 is marked other thany injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **BLOCK** FOX DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11200 FIVE SPRINGS ROAD, LUTHERVILLE, MD 21093 DAVID KURYK / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition LETBERTY PARKET SHAAREI ZION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/13/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt Cen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. acute myocardial Infarction Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to (or as a cons guence of) Atheroscierotic neart disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? chronic renai insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760

Bernice Kuryk

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Medical

State Registrar 29b. Signature and title of certifier

2008

- MP.PhD

29c. License number RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

January 11,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheisea C Pinnix, MD, PhD Sincil Hospital of Baltimore

31. Date filed (Month, Day, Year) JAN 15

4 ☐ Homicide

29a. Certifier

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 635 **Physician** MASELLA MCDANIELSKINARD 2008 January /Medical An 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Tow Bactimone NONTHWEST Conten Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 132503281 4 9 .79-Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner mites here with any long. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No BALTIMOIE **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2120 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) URSE HOME HEAlth CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Be Dorothy ROBINSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VERNON ALE APT 36 COROTHY ROBINSON 303 BROOKLYN NY 11206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State FARM, AS DAIR 1/19/2009 LAWNCEM 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ph. 11. PA WEATHER FORD FS PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3/ E, OliVER S+ BAlto MD 2/2/3 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month In the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Be Completed by RESPIRATORY 1 ☐ Yes 3 Probabiy 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Fri hyzz PNEMMOTHER 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 2 ER/Outpatient 3 DOA 1 TYes 1 Dapatient Certification: To this 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 atural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 🔛 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certi P 30. Name and address of person who completed cause of death (item 23a) (Type, Print) ORGANDO

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Yeal)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Killett /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown timore Count andallstown opnesis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 1⊠M 2□F FLORÍDA 9-2-1919 88 Director 237-56-8370 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 No Director BALTIMORE RANDALLSTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 10000 MARRIOTTSVILLE RD. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical than, Elementary/Secondary (0-12) College (1-4or 5+) CEMENT LABORER -0--3permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE GAVINS TOM KILLETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) RANDALLSTOWN , MARYLAND 10000 MARRIOTTSVILLE RD. JOSEPHINE McLEAN(SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 Removal from State GARRISON FOREST VETERANS 1-22-2008 OWINGS MILLS, MARYLAND 4 ☐ Donation DOWNer (Specify) HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fi ne al Service icense JOMTHA: 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . E fer the disease, or complications that caused the death. sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate cause (Final disease or ondition resulting in death) Advanced Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown been signed by should be detach law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 🗌 Yes 211100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 24 certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3□ DOA 1 ☐ Yes 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 296. Signature a 10 f person wh 30. Name and address

State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of Registrar	Maryland	-	rtificate of	Death		Reg. No.	108	0063/
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								3. Time of Death
	/Medic	_	Norman Louis Loudens			JANUAR	49	2008	4:53 PM		
	Examin	er	4a. Facility Name (If not institution, give street and numb		Location of Death			ty of Death			
	Funeral	, at	5. Social Security Number 6. Sex 7.	Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9 Rirthn	lace (State or Foreign
	Director		213-07-2838 X M 2 D F	Ġ	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 10), ^{rea} 1917	Mar	yland
	put »		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation				1.	0d. Inside City Limits
	faryla shoved at	ō	Maryland Baltimore	1	Catons						1 ☐ Yes 2 X No
	the N 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h with	al Di	6301 Rowe Court			2122	28		USA		
	ems ?	Funeral	11. Marital Status 12. Was Deced Arreed Forc	ent Ever in U.S es? 194	S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	194	4 7	1 □ Yes 🌠 No				ity: Whi	
9	thour atural		15. Decedent's Education (Specify only highest grade completed)	75.	16a. Dece	dent's Usual Occup	oation		16b. Kind of I	Business/In	dustry
215	hin 7% e. an "na Medi	Completed		ior 5+)	(Give life.	kind of work done DO NOT use retire	during most of worki d)	ing	Thoma	Uould	Airlines
2	ed wil ygien rer th t, the	Con	Elementary/Secondary (0-12) College (1-4	·	Me	chanic					ATTITUES
and	be fill he fill he ed off	Be	17. Father's Name (First, Middle, Last) George A. Loudenslager				18. Mother's Name	e (First, Middle, a Crosby		.me)	
Σ̈́	should nd Me mark matic	욘	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	na Address (Street	and Number or Rura			n. State. Zir	Code)
∑ S	and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show ter traumatic event, the Medical Examiner must be notified at			Son		-	rt Catonsv				
J.e.	es 1 a of Hei	-	20a. Method of Disposition	20b. Pl		sition (Name of matory or other pla		Date	20c. Location		
Ë	Page ment ant: II		1 ☐ Burial 2 ☐Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	Met	tro Cr	ematory 1	Inc. 01/1	L1/08	Baltim	ore,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Thornas Gregor		₩ 3	acNabb Fu 01 Frede	ineral Honrick Road	ne P.A. Catonsv	ville.	Marvl	and 21228
	W. Calle	Г	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
الم	Physician		Immediate Cause (Final disease or condition				Onset and Death				
	/Medical Examiner	Immediate Cause (Pinal disease or condition resulting in death) a. Love Bowa (Obstruction Due to (or as a consequence of):									
		<u>-</u>	Sequentially list conditions, b. Due to (or as a consequence of):								
4	uted	Examiner	Cause (Disease or injury		,						
J.,	rificate be executed g physician and as the burial-transit	Еха	resulting in death) Last c. Due to (or	r as a consequ	uence of):						
68760,	ate be	ledical	d		***						
		/Mec	IF FEMALE: 23c. If yes, outcome	ome of pregna	incv				201.5	-1	
Box	The law requires that the death cert tte has been signed by the attendin, bage 2 should be detached for use a	Physician/M	in the past 10 months?	th 2 ☐ Fetal nt at time of de	Ideath 3	Ectopic pregnanc Other (specify)	у		1	ate of deliventh	ery Day Year
P.O.	t the c by the ached	hysi	9 Unknown 9 Unknow								
Cords, P.	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to dea	th but not resu	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
ecords,	requir sen si sould b							1 🗆 \	res 2 □ No	3 ☐ Prot	bably 4 ⊠Onknown
Rec	e law has b	Completed						24a. Was autop	an 24b osy rmed?	b. Were auto prior to co death?	ppsy findings available impletion of cause of
			05.11					1 Yes	2 L No	1 Yes	2 🗆 No
SER.	rsicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ III	oatient 2 □	FB/Outnatie	nt 3□ DOA Oth	26. Place of Death ner: 4 ☐ Nursing Ho			ther (Speci	60
1 or	Attending Physician: r death, ector After this certifica by the funeral director, F	n: To	27. Manner of Death 28a. Date of		28b. Time o			28d. Describe h		`	97
Sion	Attending Pherical Action of the Action After the by the funeral	atio	2 Accident investigation	Luy rour,			Yes 2 □ No				
Division or Vital	or Att fter de Directa in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place o building	f injury - At ho g, etc. <i>(Specif</i> y	ome, farm, str y)	eet, factory, office		28f. Location (5 City or Tox		nber or Rura	al Route Number,
20	Hospital or 24 hours - fte Funeral Dir tely fillec in		29a. Certifier 1 ☑ Certifying Physician: To the b	est of my kno	wledge, deat	h occurred at the ti	ime, date and place.	and due to the	cause(s) and r	manner as s	stated.
1	To the Hospital or Atten within 24 hours—fler deat To the Funeral Director completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the base and manner	sis of examinat	tion and/or in	vestigation, in my	opinion, death occur	red at the time,	date and place	and due t	to the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and the of certifier			29c. Licens			29d. Date sign	ied (Month,	Day, Year)
	, \		P V. L WILL			1	,50800		Janua	\sim	9 2005
	PK,		30. Name and address of person who completed cause	of death (Item		1	a Ave	0 11-		1.	2 , 3 36
	Sta	te		HAW distrar's Signal	do do	O Cato	IN THE	Ball	more	My	0120
	Registr		JAN 1 5 2008	San San San	JO. A	1021Q					

			For State Registrar		State of Ma	ıryland	-			lealth a Death		-	giene Reg. No	20	08	00	638
B	- Physicia /Medic		1. Decedent's Name (First, Margaret Wor									2. Date of De Month JANU	Da	y 11.	Year 200	3. Time o	f Death
	Examin		4a. Facility Name (If not in:	a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towson						on	4c. County of Death Baltimore				e		
	Funeral Director		5. Social Security Number 216-24-6987		7. Age	(In yrs. la	st birthday) Yrs.	If Unde Months	r 1 Year Days	if Under Hours	Min.	8. Date of Bir (Month, Da 07-01-	th ly, <i>Year)</i> 1922		9. Birth Cou Mar	place (State intry) ryland	or Foreign
	aryland show d at	J.		dent County Baltimo	re		Town or Lo									10d. Inside C	city Limits
	with the M a or 28a-f be notifie	Directo	10e. Street and Number					10f. Zi	o Code 2109 3	3			-	tizen of V JSA	Vhat Cou	ıntry?	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Married 2	1	2. Was Decedent E Armed Forces? 1				dent of Hi			cify Yes or No Rican, etc.)		14. Rao	k, White		
2-003	"n 72 hours "natural", edical Exa	leted by	3 ⊠ Widowed 4 □ Di 15. Do (Specify only	ecedent's Educ y highest grade	Year or Dates:		16a. Dece	dent's Usi	al Occup	ation	st of workin	ng	16b. K	(ind of Bu	75	i.an ndustry	
717 D	filed withir Hygiene. xther than snt, the Me	e Completed	Elementary/Secondary (12) 17. Father's Name (First, I		College (1-4or 5-	+)		harm		t		(First, Middle	, Maider		dica ne)	1	
ylall	d Mental d Mental narked c	To Be	Ming Quay Wong Wuia							You Han Iral Route Number, City or Town, State, Zip Code)				in Code)			
, Ma	and 2 st ealth and m 27 Is r her traur		Elizabeth /	A. Hech			111	9 Fa	irbar		rive,	Luthe	rvil	le,	MD	21093	
	Pages 1 ment of H ant: If itel ury or oth		20a. Method of Disposition 1 □ Bunai 2 ☑ Cren 4 □ Donation 5 □ C	mation 3 R	emoval from State	Hiii	ace of Dispo metery, cred Ltop S corati	matory or Ervi .on	other plac CE		01-17	ate '-2008		JSON ,		Fown, State	
ספור	permit. Depart Import any inj		21. Signature of Funeral S	Service License Taua	Purd	12				ss of Facil Road	Nuc	k Tows son, M		une: 21204		Home, I	[nc.
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PNEUMONIA										etween				
	/Medical Examiner		Due to (or as a consequence of): PULMONARY FIBROSIS														
d	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SEVERE AORTIC STENOSIS Due to (or as a consequence of):														
00/00	ficate be executed physician and s the burial-transit	edical Ex	resulting in death, Last	L.	Due to (or as a	a conseque	ence or):										
O. DOX 0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									d. Date of delivery Month Day Year					
cords, P.	uires that t signed by Id be detac	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								the cause of						
ב	The law requirence to the has been since has been since the conduction of the conduc	Completed	24a. Was an autopsy performed'							DDSV	24b. Were autopsy findings available prior to completion of cause of death?						
Z .	clan: sertifica sector, I	Be C	25. Was case referred to examiner?		loonital:				Oth		e of Death	(Check only	one)				
A 10 110	ing Physi After this c uneral dire	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5	Pending	28a. Date of Injui (Month, Day	ury 28b. Time of 28c. Injury at Work?			2	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred							
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number, City or Town, State)				mber,			
	Hospital	edical Ce	29a. Certifier 120 (Check only 2 1	Certifying Phys Medical Exami	sician: To the best oner: On the basis of and manner sta	f examinati	vledge, deat ion and/or ir	th occurre	d at the ti	me, date a opinion, de	and place, and place, a	and due to the ed at the time	e cause(e, date ar	s) and m nd place,	anner as	stated.	(s)
	To the within To the comple	Me	29b. Signature and title of	f certifier	Niw) 🔊	2		se number			29d. D	ate signe	ed (Mont	h, Day, Year)	· mCl
	12		30 Name and address of	f person who co				Print)	DØ	Ø835	년		W	M	(2	. 20	<i>σ</i> 8
	Sta	ate.	GRACITO 31. Date filed (Month, Day		32. Registra	760 ar's Signat		LER	DRI	VE.	TOWS	ON. M	IARY	LAN	D 2	1204	
	Registr		INN!	1 5 2008	1. 9. Design	1 Sign		Section of the second									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30, perDVR, g875, 1/15/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PΨ MARTIN JANUARY 2008 LEV 4:47A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3304 LIGHTFOOT DRIVE BALTIMORE **BALTIMORE** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 216-20-7500 07/13/1926 NEW YORK Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3304 LIGHTFOOT DRIVE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1X☐Yes 2☐ No WW II IfYes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR EDMART** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARL LEV GUSSIE BUTENSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH LEV / WIFE 3304 LIGHTFOOT DRIVE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 01/13/2008 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Leu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Iniury 5 Pending within 24 hours aner co... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

67

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 5 2008

Neil D. Goldberg, MD Baltimore, MD 32º Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month John August Modigh /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. XXM 2 F Months Days Hours 79 220-20-9890 Director Sep.17,1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 □ Yes XXNo Director Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 303 N. Rolling Rd. 21228 Funeral U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. XXYes 2□No If Yes, Give Year or Dates: Korea XX Never Married 2 ☐ Married 1 □ Yes XXNo Specify Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Modigh ပ Mildred Orwig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Astrid Cali/Sister 15002 Haslemere Ct. Silver Spring, MD 20906 200 Mathod of Disposition | 200 Mathod of Disposition | 200 Date | 200 Location - City or Town, State | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery Pages nent of h Department of Important: If it any Injury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State 1/22/08 Owings Mills, MD 4 Donation 5 Dother (Specify) 21. Signature of Source License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Musoc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consecuence of: if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-trar Due to (or as a consequence of) Box 68760. attending physician I for use as the buria death certificate be Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an page 2 autopsy performed certificate 1 2 NO Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury within 24 hours after death. To the Funeral Director; All completely filled in hours. death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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Lock Raven Boulavard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

und)

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3:15 A.M ANNA KURSVIETIS MILLER 01 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a GOOD SAMARITAN HOSPITAL BALTIMORE 8. Date of Birth March 25,1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Lithuania 1 □ M 2 🛛 F 86 Yrs. 212-12-2160 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No **Baltimore** Directo Maryland n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 U.S.A. 6401 Loch Raven Blvd. Apt. 431 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 2 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Accountant Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Matualaitis 0na Kursvietis Pius 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 Winding Valley Drive Joppa, Maryland 21085 Daughter Katherine Rohe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of Important: If its
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount Crematory 1-15-08 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 ran Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COPI /Medical Due to (or as a conse uence of): syndrome with chronic anaenia Examiner Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CAD with Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Ves 20 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1, Inpatient 3 DOA 2 ER/Outpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

P.O. Box 68760. Division or Vital Records, certificate or Attending Physician: After this within 24 hours a

filed within 72 hours after death with the Maryland

Maryland

Baltimore,

State Registrar

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one)

29b. Signature and title of certifier

Deep Sharma

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deep Sharma: Good Samas fan Hospital: 5601 Loch Laven Block

Deep Sharma PGY2

32. Registrar's Signature

29c. License number

RESODO

29d. Daje signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 123, 2008 9:30Am Marlene Meyer Α. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Glen Burnie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 Oct. 28, Anne Arundel Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Year) 1946 1 □ M 2 🛚 F 212-46-5293 MI Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 111 Main Avenue SE 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Przbylski Marie Winkleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Carl Meyer /Husband 111 Main Avenue SE Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 2008 Brooklyn Park, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Mom ym Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GI Blead 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? 2. No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene, Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

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Examiner requires that the death certificate be executed and

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attending physician for use as the burial signed by the peen

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The	within 24 hours after death,	To the Funeral Director: After this certificate h	completely filled in by the funeral director, page

21. Signature of Fine a 23a. Part1. Hiter thi o's a shock, or heart fall re Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last n/Medical IF FEMALE: 23b. Was decedent pregnant 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 Hospital c. HUART 2 Ď. 0 BAULS

Registrar DHMH 17 Rev 1/2001

State

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Leo Raymond 14, 2008 12:30 A M Matarazzo January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 1**X** M 2□ F Months Hours Feb. 90 6, 1917 Maryland 213-03-2339 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 Reuter Road 21093 U.S.A.
14. Race - American Indian, by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any injury or other traumatic event. the Medical Evantina. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: 3 ₩Vidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Police Officer City_of_Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph Matarazzo Mary <u>Eggitto</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Madeleine Kollmann Daughter 33 Neptune Drive Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (SpeciEntombment 1-16-2008 Timonium Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Probable Wedder Cancel months disease or condition resulting in death) /Medical due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the bunial-transit and Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the bunal Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes i or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 20 Other (Specify) W57 4 1 ☐ Yes 2 ☐ No ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 🖾 Natural 5 Pending (Month, Day Year) М investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

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31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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N. Charles ST TONSON NO 21204

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MOLLY JANUARY 2008 9:15 P M MILLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SHADY GROVE NURSING HOME ROCKVILLE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/10/1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 118-18-4589 84 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. Count 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MONTGOMERY **POTOMAC** MD Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9440 NEWBRIDGE DRIVE, #108 20854 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Midical Examiner once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RALPH GABAY STELLA NEGREE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) POTOMAC, MD 9440 NEWBRIDGE DRIVE, #108, SANDRA MILLER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/12/2008 BOYNTON BEACH, FL 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIALATED CARDIOMYOPATHY 1 YR Sequentially list conditions. Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine A puer Due to (or as a consequence of) attending physician a I for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 HYPERTENSION 3 Probably 4 to Unknown 1 ☐ Yes 2 No Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform CONGESTIVE HEART FAILURE 1□ Yes 2 X No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA ပ 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined 1 ሺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D28656 JANUARY 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVI PASSI, MD 8609 SECOND AVE., #404B SILVER SPRING, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** Miller Diamond 2008 15-11 Okiva 10 anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Mrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2**X**] F 0 N/A 10,2008 Maryland Director Jan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1√2 Yes 2 □ No Director MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 246 N. Spring Court 21231 USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A12 should be filed whand mand Mental Hygier 12 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orpheus Kittrell Atiya Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 246 N. Spring CT. Baltimore, MD 21231 Atiya Miller - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 1-14-2008 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary hypertension **Physician** /Medical Due to (or as a con equence of): Examiner Prendurity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

Yang

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

North Wolfe Street

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Baltimore, Mary land

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🕦 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** elson 10,2008 anieL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner**) o Seph itchie thm المسلق If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -14-0772 1MM 2 F Yrs South Carolina Director 2 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 □ No Funeral Director nd. timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No Armed Forces l ☐ Yes 2 ☐ f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker ainTenanco 10th NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) _ no ther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an #106 Bacto. MIS Owa 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State mportant; If 4 □ Donation 5 □ Other (Specify)

21. Signature of scheral Selvice Livensee rematory 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death iva failure Immediate use (Final Physician disease or condition resulting in death) Ima /Medical Due to (or as a consequence of): Examiner Melastatue mercutice. lino. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9☐Unknown O 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, ş 4 Nknown abuse 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 2 10 1 🗌 Yes Certification: To Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred KICHENTOSPICE 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Methal 800 10, 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. EURHW ST. HOSPICE とりかです 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician Darre1 Gehrig Neeb 2008 anuaru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimole Washington Medical Center BURNIE If Under 24 Hrs. ANNE APUNDEL LEN 8. Date of Birth (Month, Day, Year) May 3, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 → M 2 □ F **Funeral** Days 69 191-26-9607 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the M dical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10a. Citizen of What Country? U.S.A. 321 Wende Court 21061 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No à Specify: Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 12 N.S.A. U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Virginia Fronheiser Henry Neeb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Neeb/Wife 321 Wende Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Ϊ5, Jan. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 2008 4 Donation 5 Dother (Specify) Stevensville, MD 22. Name and Address of Facility $Singleton\ Funeral\ \&\ Cremation$ 21. Signature of Funeral Service Licensee Mo/357 Services 1 2 nd Avenue SW Glen Burnie, MD 21061 ancure 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ◯ No 24a Was an certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[X No Inpatient 1 🗌 Yes ည 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

> 3 State

29b. Signatur

31. Date filed (Month, Day, Year)

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Registrar

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of persim who completed cause of death (Item 23a) (Type, Print)

32.

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 10, **Physician** 2008 3:15 PM Patrick C. Phelan Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2 Burnbrae Road Towson Baltimore 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 17, 7. Age (In vrs. last birthday **Funeral** Days 1X M 2□ F 213-10-7833 1913 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at a or 28a-f sho t be notified a 1 □Yes 2 No Director Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2 Burnbrae Road 21204 **USA** "natural", or items 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 \ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Physician Surgeon Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick C. Phelan, Sr Mary Joseph Peach ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick C. Phelan, III., Son 2 Burnbrae Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Metro Crematory Inc. 01/12/08 Baltimore, Maryland 21. Signature of Funeral Service Liversee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 any Ir Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscleritic C. -diosisulor discose Physician eur /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performer Yes 2 certificate 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2No 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after (4 ☐ Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 24 and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥

State

Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ron Zer

32. Registrar's Signature

23a) (Type, Print) M. D. 6569 N. Cl. J. s S+ #600 B. 12 mc/ Z)Z04

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			1- For State of Maryland / Depa	rtment of Health and N tificate of Death		ne . N. 2 (1 (1 (8)	00650
-	Dhysisia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Ruth Miriam Preston		Jan. 12	, 2008	6:40 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Fair Haven	4b. City, Town, or Location of Death		4c. County of Dear	
	Funeral		5 Social Security Number 6 Sex 7. Age (In vrs. last birthday)	Sykesville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carr	thplace (State or Foreign
	Director		230-44-4930 1 M 2 73 Yrs.	Months Days Hours Min.	Feb. 24,	1934 Ne	ew York
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	'n	10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits 1 □Yes ②□No
	the M 28a-f notifie	ect	MD Carroll Sykesv	1 L L E 10f. Zip Code	10a	. Citizen of What Co	ountry?
	3a or	Ö	7200 3rd Ave. Apt. A204	21784		U.S.	Α.
	death	Funeral Director		⊥ /as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
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<u>.</u>	in 72 in "na Medic	Completed	(Specify only highest grade completed) (Give k life. D Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work O NOT use retired)	king	or raina or baomood,	masay
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מב	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Health a	Be	17. Father's Name (First, Middle, Last) Thomas Edward Dickson		ne (<i>First, Middle, M</i> a B eatric		
<u> </u>	shoul ind Me i mark umati	10	,	g Address (Street and Number or Ru			Zip Code)
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10	of He		20a, Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition 2 □ Cremetery cremitery. Crem	ition (Name of parory or other place)	Date 20	c. Location - City or	Town, State
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	ding I	tion:	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
ivision or	Atten r deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, streed building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or R	tural Route Number,
5	To the Hospital or Attending Physician: The law requires that the death certificate be ewiwithin 24 butus after death certificate be ewiwithin 24 butus after death of the this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death				hateta a
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)	4		- wage no	1000581	37	1/14/8	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) (+207 (+100)	37 trinster	2071	157
	Sta	te	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	7/ 7/ CUTY	1 NINSTE	, , , , ,	
	Registr		JAN 1 5 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** O M orraine 2008 /Medical . County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, gi Examiner Annapolis MD Anne Ar Medical Center 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Country 1 □ M 2 🗷 F 85 218-12-6959 Maryland 14,1922 Director Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State Maryland Anne Arundel 1 ☐ Yes 2 No Director Curtis Bay 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code within 72 hours after death with U.S.A. items 23a Examiner must Funeral 110 Kingsway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No ŏ Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 MWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth John A. Poe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau 7776 Bridge Street, Pasadena, Maryland 21122 Elton Peeler (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 01-18-08 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funda Service Licente 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. Payl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 21122 Approximate Interval Between Onset and Death immediate Cause (Final isease or condition resulting in death) Physician da /Medical to (a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as t the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No KIDNEY 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform page PS1 certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No tospital or Attendi I hours after death. 'uneral Director: A death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 13,2008 12:45aM Edna Doris Padgett 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Wonth, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Sept. Pay, 1 □ M 2 🖸 F 75 215-28-0029 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 12 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Of America 21236 3832 E. Joppa Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 12 Married 1 ☐ Yes If Yes, G 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Ralph Deterio Enterpriso Payroll Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Mae Schultz Jasper King Steven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3832 E. Joppa Road Baltimore Maryland 21236 Norman A. Padgett-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State Jan. 15,2008 Parkville, Maryland Moreland Memorial Prk 4 □ Donation 5 □ Other (Specify) 21. Anature of Fun ral Service Licensee EVANS FUNERAL CHAPEL & CREMATION SERVICES 8800 Harford RD., Parkville MD. 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygie s marked other th

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of Health at It item 27 is

Pages 1 gment of He

permit.

The law requires that the death certificate be executed

attending pl

been signed by the should be detached

director,

Director:

Funeral D 24 hours

within 2

Medical

Records, P.O. Box 68760,

Division or Vital

Hospital or Attending Physician:

or other

Department of Important: If any Injury or once,

ould be f

the Medical

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed

Examine Physician/Medical ģ Be Completed Certification: To

25. Was case referred to medical examiner? 1 Tyes 27. Manner of Death 1 Death

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

217 No

2 Accident

24a. Was an autopsy perform

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier d manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

nembo.

5 Pending investigation

29c. License number

29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day Year)

6535 N. Cinarles ST Stesso 31. Date filed (Month, Day, Year

State Registrar

5

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 68 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ballo ma If Under 24 Hrs Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🛂 Director 7-28-28 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 518 Fairview Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Hostess <u>School</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) Tina William J. Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Orolin - Niece Cardiff Ave. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 1-16-08 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition AN COM Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 🗆 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 probably 4 ☐ Unknown been si Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy performed? res 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA P 1 Inpatient this After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🛱 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the place of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760, P.0. Records, Division or Vital Physician: the Hospital or Attending within 24 hours at er death.

To the Funeral Director A completely filled in by the fi

Baltimore, Maryland 21215-0036

lame and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

State

Medical

Registrar

DHMH 17 Rev 1/2001

26 32. A sistrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:39 AM ANUARY 2008 Elizabeth Jean Rennie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1□M 2**X**F Yrs JAN 14 1922 California 85 569-24-1258 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 1 □Yes 2 X No MD Prince Georges Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770 USA 7307 Sunrise Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Griffith Claflin Thomas Roy 19a. Informant's Name/Relationship (Type. Prindaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy G. Rennie-Zelina, 7307 Sunrise Court, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 1/11/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sceneral H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lepsus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or all a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown discrete 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 26. Place of Death Check onl one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

iled within 72 hours after death with the

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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and burial-tran attending physician the use as s been signed by the should be detached cate has been s , page 2 should

Physician:

P.O. |

Division or Vital Records,

Hospital

Physician/Medical IF FEMALE: þ Completed Be

Examiner

Certification:

After this death.

the fineral director, within 24 hours after death To the Funeral Director: filled in by aner

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 → Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

1/10/08

MD D0062116

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7705 Belle, Point Drive, Greenbeit,

WORKNEH MEKLIT

31. Date filed (Month, Pay, Year) 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle 2. Date of Death . 10 pM **Physician** 800 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Loac 0 more 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) last birthday **Funeral** Hours Min 220-20-2967 1 ☐ M 2 🕱 F Apr. 17 Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adral Examiner must be notified at Baltimore 1 XYes 2 ☐ No Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT (se retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) oryrs 18. Mother's Name (First, Middle, Maio Rural Route Number, City or Town, State, Zip Code item 27 20a. Method of Disposition permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. Burial 2 □ Cremation 3 □ Removal from State Baltimore, 08 4 Donation 5 Dother (Specify) 21. Signature of Funer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** $1c\iota$ Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 I Nursing Home 5 Residence 6 □Other (Specify) After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after decreased and by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral C

completely filled i 29a. Certifier l 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) certifier 30. Name and addre 31. Date filed (Mo. 32/Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		artment of F		_	giene Reg. No.	008	00657
	Physici	an	Decedent's Name (First, Middle, La	ist)		Diah		2. Date of De Month O1	Day	Year	3. Time of Death
	/Medic	al	Evelyn 4a. Facility Name (If not institution, giv	en etroet and number)		Rigb	Y r Location of Deat		08	2008 County of Death	2:00p M
	Examin	er				Bel.		11	40.	Harfor	d
	Funeral Director			Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			y, Year)		place (State or Foreign
			Usual Residence of Decedent					14 1	9 9		
_	death with the Maryland ms 23a or 28a-f show cmust be notified at	or	10a. State 10b. County MD Harf		10c. City, Town or Lo ${\sf Bel}\;\;{\sf A}$						1 □ Yes 2 ☑ No
P	28a-f	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	ten of What Cour	
3	3a or	D	1842 Wye Mills	Lane			015			U.S.A.	
	ems 2	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No	- 1	4. Race - Americ Black, White,	
36	72 hours after natural', or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 No If Yes, Give X	·	1 ☐ Yes 2√2 No	Specify:				ack
21215-0036	2 hour	ed b	15. Decedent's E			dent's Usual Occup			16b. Kir	nd of Business/In	dustry
215	within 72 ene. than "na	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+	life.	kind of work done DO NOT use retired	during most of wo d)				
	ygien ygien t, th	Con	12th grade	5yrs_	Huma	n Resou				i Hosp	ital
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. If Health and Mental Hygiene "natural", or Items 23a or 28a-f show tiem arked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evandor must be notified at	To Be	17. Father's Name (First, Middle, Last Cle Arthur Bod					me (First, Middle,		Sumame)	
Man	12 sho h and 7 is ma Irauma		19a. Informant's Name/Relationship			ng Address (Street Gunthe					Code)
	s 1 and 3 f Health item 27 other tr		Dorothy Davis- 20a. Method of Disposition	Aunc	20b. Place of Dispo cemetery, cres			Date		cation - City or To	
E O			1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		i	matory or other place morial	l l	19/08	Ran	dallst	own. Md
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice		_ 22	2. Name and Addre	ss of Facility	13/00	Ran	GGILDC	Owilly III
<u> </u>	Per Dep Imp	10	Atome +	Shumpai	V JR 4	1300 Wab	ash Ave			e, Md	21215
			23a. Part1. Binter the disease, or con shock, or heart failure. List only	plications that caused the one cause on each line			-				Approximate Interval Between Onset and Death
	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	a cuter		votic C	ardie	asoulo	w d	isease	<u> </u>
	Examiner		- (Due to (or as a	consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):						
113.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Duo to (or as a	consequence of):						
87609	ite be execul iysician and ne burial-trar	ical E	l	Due to (or as a	consequence on.						
687	ificate g physical as the	ed	•	d							
Вох	death certificate e attending phys id for use as the	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy	,		2	3d. Date of delive	*
	e deat the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 ☑Unknown	4☐Pregnant at ti		Other (specify)				Month	Day Year
P.0	v requires that the de been signed by the should be detached	Ph)	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco u:	se contribute to t	he cause of death?
ecords,	uires n sign	d by		Vone				1 🗆 '	Yes 2	(No 3□Prot	oably 4 Unknown
000	law requir as been si 2 should	olete	,					24a. Was		24b. Were auto	opsy findings available
α	0 1 0	Completed						autor perfo	rmed?	death?	mpletion of cause of
	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o			Δ
of V	S 0 = 0	၉	1 Yes 2 No	Hospital: 1 Inpatient			4 🗆 Nulsing i	lome 5 Resi			(y)
	Jing After fune	tlon	27. Manner of Death 1 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
Division	Attending in death. ector: After by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	28e. Place of Injur	y - At home, farm, str			28f. Location (- City or Tox			al Route Number,
Ö	itel or A rs after ral Directed In Directed		4 - Notificide	building, etc.	(эрвспу)			City or Tol	wii, State)		
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical		nysician: To the best of miner: On the basis of e and manner state	xamination and/or in						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 / 1110		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			Isemand ye	ma 1111,11	ME	1001	4206	0	bone	104 9,2	2008
	10		30 Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print) 6/4 C/44	RCHVIL	LE RO	(B)	ELAVR	Md 21015
	Cto	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature					/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jahuary 12, 2008 **Physician** Angela C. Raymond 7 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Oak Crest Care Center Parkville Baltimore 8. Date of Birth (Month, Day, Year)
November 3, 1913

9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M & F 377-03-9368 94 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore Parkville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? marked other than "natural", or items 23a or matic event, the Medical Examiner must be i 8800 Walther Boulevard 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White ò 3☐Widowed 4☐Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H filtem 27 is marked oth or other traumatic even Be Jacob Shinar Mary Kruppa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Ferretti/Daughter 4102 Chardel Road #3H Nottingham, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages of Pepartment of Himportant: If Ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment Gardens Of Faith 1/17/08 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscleroke Cardwoosula dioase Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): acute on chance Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Mentenow Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALMON! 2 No 3 Probably 4 Nnknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed? 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes မ 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) weth Blod Parkolle MD 31234 MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			Pleas	e Type or Pri						_		_	
			For State Registrar	State of M	laryland		triment of tificate o			ientai Hy	/giene Reg. Ng	0000	00659
	Physicia	an	1. Decedent's Name (First, Middle,		_					2. Date of D Month	Da		3. Time of Death
	/Medic	al	Eugene Norma				4b. City, Town	or Location	of Death	Januar		0 2008 County of Death	8:45 p ^M
1	Examin	er	4a. Facility Name (If not institution, Rockville Nursi		7)		Rockv		Oi Dealii			Montgom	
	Funeral				Age (In yrs. las	st birthday)	If Under 1 Ye	ar If Under	r 24 Hrs.	8. Date of Bi (Month, D	irth	9. Birth	place (State or Foreign intry)
星	Director		131-14-4/54	1 4 № M 2 F	80	Yrs.	Wichting Day	73 110013	IVIII.	MAY 16			York
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryl -f sho	ţ	MD Montgo	omery	Si	lver	Spring						1 ☐ Yes 2 X No
	or 28a	irec	10e. Street and Number				10f. Zip Code	9			10g. Cit	tizen of What Cou	untry?
	23a c	ral	9145 Sligo Cree				209					USA	
	er dea Items	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces d 1 X Yes 2 □	\$?	. 13.	Was Decedent of If Yes, specify C	of Hispanic O Suban, Mexica	rigin? (Sp an, Puerto	ecity Yes or N Rican, etc.)	0-	14. Race - Amer Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		5	1∐Yes 2 X N	lo Specify	<i>r</i> :			Specify: Wh	ite
ğ	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Oc	cupation	st of work	ina	16b. K	ind of Business/I	
21215-0036	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or			kind of work do DO NOT use ret			9		- n 1	
	filed within Hygiene. rther than "	Õ	17. Father's Name (First, Middle, La	ast)		Direc	tor & W		ner's Nam	e (First, Middle		m Produc	ction
and	d d d	To Be		Starbecker				Vi	ctor	ia Do	roth	y Gree	er
Maryland		-	19a. Informant's Name/Relationshi	ip (Type. Print)		19b. Mailir	ng Address (Stre	et and Numl	ber or Rui	al Route Num	ber, City	or Town, State, Z	ip Code)
_	1 and 2 Health a tem 27 is		Marcia Marlow St	arbecker -									MD 20901
Itimore,			20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3	3 □Removal from State	e i		sition (Name of matory or other)	1		Date		ocation - City or	
<u>=</u>	구두모근		4 Donation 5 Other (Special Service)	ecify)	Metr		ematory,					ltimore,	MD
Ba	permi Depar Impor any Ir		21. Signature of Funeral Service U	Thomas Gre	gor	-	Cremati 299 Fre	on Soc derick	iety	of Mar 1. Ralt	ylar imor	d, Inc.	21228
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that cause	ed the death.	Do not ent	er the mode of	dying, such a	s cardiac	or respiratory	arrest,		Approximate Interval Between
Te	Physician		Immediate Cause (Final disease or condition		iiio.								
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit at	Medical Certification: To Be Completed by Physician/Medical I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a Cardi Due to (or a Cardi Due to (or a Carot Due to (or a Diabe 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown as contributing to death Hospital: 1 Inpa 28a. Date of in (Month, Date of in building, in 28a. Place of in building, in 3 Physician: To the besis and manner: 3 Physician: To the besis and manner: 3 Physician: To the besis and manner:	as a conseque LOVASC as a conseque LIGAT as a con	Pance of): Cular ence of): Ctery ence of): felli cy death 3E ath 5E ath	Disea Lus Control of Disea Lus Control of Disea Control of Door o	given in Part 26. Plac Other: 4124 Nork? DYes 2 ce e time, date any opinion, di ense number 047330	Meta It I. Coe of Deat Nursing H No and place eath occur O	23e. Did 1 24a. Wa aut per 1 Yes th (Check only 28d. Describe 28d. Describe 28f. Location City or T	I tobacco Yes 2 Is an opsy formed? You one) Sidence e how injute (Street a own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Own, State and Ow	Month use contribute to P No 3 Pr 24b. Were au prior to o death? Other (Spec ury occurred and Number or Ru s) and manner as nd place, and due ate signed (Montri	very Day Year the cause of death? obably 4 Onknown topsy findings available completion of cause of 2 No cify) tral Route Number, stated. to the cause(s)

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Seamon Grace 01 ZOOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A University Maryland Medical Center Baltimore 0 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Aug 22, 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs **Funeral** Days Hours 1□M 2XF Months 85 216-14-0487 1922 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code f Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 2 other traumatic event, the Medical Examiner must be n 4503 Frederick Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturali", or Iten any injury or other traumatic event. the Medical Eventant 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Florist Shop Owner Floral 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Reinemer Marquerite Brookheiser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Seamon, Son 1297 Highland Drive Moscow, ID 83843 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/15/08 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Ricensee

Thomas Gregor 22 Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arguments shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or complications one cause on each line.

Immediate Cause (Final disease or complications)

a. Introcurrent at the mode of dying, such as cardiac or respiratory arguments.

Due to (or as a consequence of):

B. Hypertension Approximate Interval Between Onset and Death 19 days Physician /Medical Examiner Hypertension Due to (of as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical been signed by the attending p should be detached for use as: IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 has autopsy perform certificate 2 No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending investigation SUBTECT FELL death. 1 TYes 2 Accident 12/24/07 unknown after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 706 GRATING AVE, CATONSVILLE, MD Home within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18239 01 13 Od

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

South

Greene

Bultimore, Mary Ind

21201

Street

erson who completed cause of death (Item 23a) (Type, Print)

NARRYAN

32. Registrar's Signature

MAYIM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aniend item 11 per fh 8875 1-15-08 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LORETTA **EVELYN** SOUSTEK 16:46 M 2008 Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore- Washington Med. Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) March 22,1913 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 Months Davs Hours Country) Maryland 94 218-14-6140 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No Director Anne Arundel Pasadena Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2009 Fraley Lane 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Notarried White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 XWidowed 4 ☐ Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mullen George Ireland Martha ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Fraley Lane, Pasadena, Maryland 21122 Belinda Fraley Huesman (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem.Park 4 □ Donation 5 □ Other (Specify) 01-17-08 Glen Burnie, Maryland 21. Signature of Fusera Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. <u>3204 Mountain Road, Pasadena, Maryland 21122</u> nt1. Enter the disease, or complications that caused the death, snock, or heart failure. List only one cause on vac. line. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final isease or condition resulting in death) **Physician** /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician a the burial Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 It Inknown 23e. Did tobacco use compute to the cause of death? Records, 2 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a Was an Was an autopsy performed Yes 2 certificate has death? 1 ☐ Yes 1□ Yes **Division or Vital** funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA Certification: To 1 🔲 Inpatient this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Sign b

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Year 2008 anuga /Medical 4c. County of Death Facility Name (If not instit 4h City Tewn or Location of Death Examiner ont 07 TIMORE If Under 24 Hrs. (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 3/ F 107-56-9031 Director 08 NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or theme 27 is marked other than "natural" or theme 22 is any Injury or other trainmatic. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 7316 Fairbrook Road U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th Grade College (1-4or 5+) Caldor Company Admin. Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ouentilla Watford Rufus R. Cherry Sr. ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Cherry-Brother 8022 Watermill Ct. Elkridge, Md 21075 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Qonation 5 ☐ Other (Specify) 1/16/08 Ahoskie, NC 21. Signatur of Funeral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the harial Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by a page 2 should be detach conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significa 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 40 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Thpatient 2 2 ER/Outpatient 3 DOA 27. Manner o Death 28a. Date of Injury 28h. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident (Month, Day 5 Pending investigation 1 Tes 2 No after death 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Certifier 29c. License number w 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South 31. Date filed (Month, Day) Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

5 2008

DHMH 17 Rev 1/2001

SHERWOOD,

			State of Maryland / Department State of Maryland / Cer	ortment of Health and Mattificate of Death		ene 2008 00664 g. No.
	413		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Marie Hicks Storm		January	11, 2008 4:57 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
-	HE !		204 E. Joppa Rd. Apt. 714	Towson		Baltimore
	Funeral Director		5. Social Security Number 174-10-3355 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
	w	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lor	cation		10d. Inside City Limits
	faryla sho ed at	ō	MD Baltimore Towson			1 ☐ Yes 2X No
	the N	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	with 3a or t be	Ö	204 E. Joppa Rd. Apt. 714	21286		USA
	ms 2;	Funeral		Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,
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ה ה	72 h	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of worki	ng 1	6b. Kind of Business/Industry
7	vithin ne. han '	Id II	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired) Homemaker		Own Home
7	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at		12 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	
	d 2 should be filed within th and Mental Hygiene. 77 Is marked other than traumatic event, the Me	Be c	Howard Dilts Hicks	Bertha		hausler
Š	hould nd Me mark matic	မ		ng Address (Street and Number or Rura		
2	nd 2 s Ith an 27 Is trau		Andrew Lang (grandson) 810			
עֿ	Health tem 27 other tr	- 1	20a Method of Disposition 20b. Place of Dispo	sition (Name of		20c. Location - City or Town, State
	ages ent of rt: If I		1 1 (Burial 2 MCremation 3) (Bernoval from State)	Svc. Corp. 01/1	5/2008	Towson, Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22	Name and Address of Facility Ru	ck Towso	n Funeral Home, Inc.
_	20 = 20			050 York Road, To		
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	or respiratory arre	st, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			vers
	/Medical Examiner		Due to (or as a consequence of):			
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	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			YEARS
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0	ificate g phy as the					
5	h cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery
	death	sicia	in the past 12 months? 1 □ Yes 2 ☑ No 4 □ Pregnant at time of death 5 □	Other (specify)		Month Day Year
5	at the by th tache	hys	9 Unknown		T	
ń	es this	by F	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
COI CO,	requir	ted			The second	
נו	law las b	Completed			24a. Was an autopsy	y prior to completion of cause of
=	: The cate I	S			perform 1□ Yes 2	ned? death?
V II a	Iclan Sertifi ector	Be	25. Was case referred to medical examiner? Hospital: A Dispersion of DERICO transfer.	26. Place of Death	,	
5	Phys this al dir	^L	1 ☐ Yes 2 ☑ No ☐ HOSpital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death	IL 3 DOA 4 Nursing Ho	me 5. Reside	nce 6 Other (Specify)
5	ding F	ion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	zod. Describe no	w many occurred
0	death death ctor: y the	licat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, str		28f. Location (Str	reet and Number or Rural Route Number,
2	l or A after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town	, State)
	spita Nours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place,	and due to the ca	ause(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, da	ate and place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
	1.		Dise Sattephs MD	043172	J	Tan. 14, 2008
	D		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	•		Lise Sittenfield 515 Fair	- mount Are.	Torson	MD 21286
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	a de		
	Registr	ar	JAN 1 5 2008 1 1000 18 19	www.		

erem	y David S	tagr			delible Ink. Ensur artment of Health ar			oie.	
		_	1- For State Registrar		tificate of Death	ia mentan nygi	Reg. N	yo 200	0 0066
	Physici		Decedent's Name (First, Middle,Last)				Date of Death	Sm (3 -	3. Time of Death
Medic	al Exami	iner		9			Month Da anuary 9, 20		0725 hrs
			4a. Facility Name (if not institution, give s 8192 Mountian Estate Court	·	4b. City, Town, o Pasadena	r Location of Death		4c. County of Death Anne Arundel	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		ar If Under 24Hrs. 8	. Date of Birth (N	//////////////////////////////////////	place (State or
	Director		213-17-3677 1XM	2 F	28 Yrs. Months Day		09/01/	Foreig	
	_		Usual Residence of Decedent				03/01/	1373	
2	w any		10a. State 10b. County	,	Town or Location				10d. Inside City Limits
20	yland -f sho once,	tor	Maryland Anne Ar	undel		asadena	- Lea	0	1 Yes 2 No
29,11	th the Maryland 23a or 28a-f sho notified at once.	Director	8192 Mountain Est	ata Court	10f. Zip Code	21122	10g.	Citizen of What Coun USA	uy?
	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once			2. Was Decedent Ever in U.	S. 13. Was Decedent of H		fy Yes or No-	14. Race - Americ	an Indian, Black,
	death r item	Funeral	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 No		n, Mexican, Puerto Ric		White, etc.	
	after al", o iner n			Yes, Give Year r Dates:	1 Yes 2 X No			Specify: Wh	ite
		ed l	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed) College (1-4 or 5+)	16a. Decedent's Usual Occupa during most of working life			b. Kind of Business/Ir	ndustry
36	hin 72 e. than '	ple	12	College (1-4 or 5+)	Sales Ass	ociate		Furnitu	ire
-00	filed within 72 hours I Hygiene. ed other than "natur t, the Medical Exami	Completed by	17. Father's Name (First, Middle, Last)			18.Mother's Name (Fi	rst, Middle, Maid		
21215-0036	wuld be fill Mental F marked c event, f	Be	Edward Sta			Jewel	Brai		
	ages I and 2 should be find of Health and Mental It: If item 27 is marked other traumatic event,	٢	19a. Informant's Name/Relationship (Type Amanda Stagno	e, Print) (SDOUSE)	19b. Mailing Address (Stre 8192 Mounta				
MD	l and 2 shou Health and I fitem 27 is ir		20a. Method of Disposition	20b. F	Place of Disposition (Name of co			Oc. Location - City or	
Jore	ages I nt of F it: If i		1 Burial 2 X Cremation 3		crematory or other place) Cro Crematory I			Baltimore,	Markland
Hin	permit. Pages I and Department of Heal Important: If item injury or other tra		4 Donation 5 Other Specify: 21. Signature of Funeral Stryice Lice up		22. Name and Addres	(P			
ä	Dep Imi		Ch Ish K		3111 [10	untain Road	d. Pasad	Funeral H	ome, P.A. 1122
	hysician Medical		23a Part I. Enter the disease, or complication failure. List only one cause on each	ations that caused the death. line.	. Do not enter the mode of dying	, such as cardiac or re	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
	caminer		Immediate Cause (Final disease a	Methadone and co	caine intoxication	n			Death
				e to (or as a consequence of	r):				
		ner	Sequentially list conditions, if any, leading to immediate Du cause. Enter Universitying Cause	e to (or as a consequence of	f):				
		Examine	(Disease or injury that initiated C	e to (or as a consequence of	f):				
	e executed cian and rial - transit		d		5 7-7				
	be exe sician urial -	Physician/Medical	X UNPENDED	MENDED #23a,27,28a-f. τ	oerME,0875, 1/25/00	3 TT			
Box 68760	rtificate be ling physici as the buri	J/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy Fetal death 3			23d. Date of delivery Month	ay Year
39 ×	leath certific e attending for use as t	icia	past 12 months?	4 Pregnant at time of dea	2	cotopic pregnancy	9	Month	ay 1001
	he dear the at hed for	hys		9 Unknown					
P.0	The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the buri	by F	Part II. Other significant conditions co	intributing to death but not re	esulting in the underlying cause	given in Part I.		cco use contribute to	
	w requires s been sig should be						24a. Was an		topsy findings available
cor	law r has b e 2 sho	Completed					autopsy performe	prior to o d? death?	ompletion of cause of
8	cian: The certificate ector, page		25. Was case referred to medical		26 Plan	e of Death (Check only	1 Yes 2	No 1 ✓ Ye	s 2 No
of Vital Records,	g Physician: fter this certifi neral director,	o Be		pital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursing H		sidence 6 🗸 Other	: Scene
ð	ding Ph L. After t funeral		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Inj	ury at Work? 28	d. Describe how	injury occurred	
Division	teath tor:	ertification	1 Natural 5 Pending 2 Accident Investigation	Fnd 1/9/2008	unk	Yes 2 X No u	nik		
i.	pital or Attene ours after death teral Director: filled in by the		3 Suicide 6 X Could not be determined		ome, farm, street, factory, office		or Town, State	e)	ral Route Number, City
L	lospita i hours unera iy fille	0	29a. Certifier A Continue Physician	(Specify) Home	no death convered at the time of				t. Pasadena, M
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) Medical Examiner: 0	n the basis of examination ar	ge, death occurred at the time, on nd/or investigation, in my opinion				
	To With	Me	29b. Signature and title of certifier	nd manner stated.	29c. Licen	se number	25	9d. Date signed (Mor	nth, Day, Year)
	17		1 lakober	W	O.C	.M.E.	J	anuary 9, 2008	
	7		30. Name and address of person who con						
0	1		Laron Locke MD. Assistar 31. Date filed (Month, Ray) Year) 5 7 7	nt Medical Examiner 32. Registrar's Signatu	111 Penn Street, Balti	more, MD 21201			
	8	ate	JI. Date lieu (MO/II/I Baylyear) [1]	TIXE OZ. INCHISTRALS SIGNATU	THE AMORAGE I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar					Certificate of Death Reg. No.				1000	
В	Physici	ian	Decedent's Name (First, Midd	dle, Last)		CHC	`^D	2. Date of Dea Month	Day	Year 71	ne of Death
	/Medi	cal	MORRIS 4a. Facility Name (If not institution	on give street and symbo	-1	SUG	AK or Location of Death	7 Km	4c. County of		IAm :
1	Examir	ner	SINAI HOSPITA	AL OF BALTIMO	ORE	BALTIMOF	RE		1	N/A	
	Funeral Director		5. Social Security Number 217-16-7369 Usual Residence of Decedent	6. Sex 7. A	nge (In yrs. last birtho 84 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 05/31/	1923	9. Birthplace (Sta Country) MD	ite or Foreign
	/land low at		10a. State 10b. County	у	10c. City, Town o	r Location					e City Limits
	a-f sh ified	to	MD BALT	ΓΙΜΟRE	BALT	TIMORE				1 🗆 '	Yes 21 No
	ith the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W		
	eath w s 23a nust k	iral	6713 CHIPPEW		4 5 mm (n 11 0	10.11.	21209		14 Deep	USA	
980	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mai 3 □ Widowed 4 □ Divorced	If Yes, Give	No MMII	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		ecity Yes of No- Rican, etc.)	Black Specify:	- American Indiar c, White, etc. WHITE	1,
5-0	72 h	etec	15. Decede (Specify only high	ent's Education lest grade completed)	1 (0	ecedent's Usual Occup Give kind of work done	during most of work	king	16b. Kind of Bus	siness/Industry	
121	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	fe. DO NOT use retire SALESN	•		UPI	HOLSTERY	
d 2	illed Hygi other	Be C	17. Father's Name (First, Middle	, Last)			18. Mother's Nam	e (First, Middle,			
/lar	should be filed wind Mental Hygie marked other tumatic event, the	To B	FREIDEL		SUGA	\R	BESSIE		S.	ILBERMAN	
, Maryland 21215-0036	12 h a		19a. Informant's Name/Relation	, , , ,	671	failing Address <i>(Street</i> L3 CHIPPEW <i>F</i>	A DRIVE, I			State, Zip Code) 21209	
Baltimore,	of the second		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (a		e B NAI	isposition (Name of crematory or other pla SRAEL CONG	G. 01/1	Date 4/2008		ORE, MD	е
alti	permit. Pag Department Important: I any Injury o		21. Signature of Juneral Service	e Licensee		22. Name and Addre				ROS., IN	
	80 E # 9		Jay (XI)	27-		8900 REIS					
	Physician /Medical Examiner	ıer	23a. Part1. There the disease of shock in the failure. List immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a.	s a consequence of)	estil	infine	h:m	est,	76	imate I Between and Death Upwin Month
	nd Auted	Examiner	Cause: Enter Onderlying Cause: Obsease or injury that initiated events resulting in death) Last	C							
60,	be execian a		resulting in death) cast	Due to (or as	s a consequence of)						
68760,	ficate physi s the b	Medical		d	·- ·· ·			-			
P.O. Box (requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 □ Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date Mon	e of delivery nth Day	Year
<u>S</u> , Р	res that igned b	<u>م</u>	Part II. Other significant condit	ions contributing to death	but not resulting in th	ne underlying cause giv	en in Part I.			bute to the cause	. .
örc	w require been sign	eted	Lower Gar	the int	() VOCC	Wheed	1				Onknown
Rec	a	Completed	Service for	3/10/10912	3 house	nuce	The same of the sa	24a. Was a autop perfor	sy p med? d	Vere autopsy findir rior to completion eath?	ngs available of cause of
ita		Be Co	25. Was case referred to medica	al			26. Place of Deal			□Yes 2□No	
<u>r</u> <	S D	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpat	tient 2 ER/Outpa	atient 3 DOA Oth	or:		ence 6 □Othe	r (Specify)	
o uc	ing P. After t funera		27. Manner of Death Natural 5 □ Pendi	28a. Date of Inj ing (Month, D		ry Wor		28d. Describe h	ow injury occurre	be	
Division or Vital Records,	• Hospital or Attending 24 hours after death. • Funeral Director: After etely filled in by the funer	Certification:		mined 20e. Place of In	njury - At home, farm etc. <i>(Specify)</i>	M	Yes 2 □ No	28f. Location (S City or Tow		er or Rural Route I	Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyl (Check only one) 2 Medical	ing Physician: To the bes if Examiner: On the basis and manner s	of examination and/	leath occurred at the ti or investigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and mar	nner as stated. and due to the cau	ıse(s)
	To the l within 2. To the I complet	Me	29b. Signature and title of certific	er A		29c. Licens	se number			(Month, Day, Yea	-
	i		Wylen	1/W).		70	41817		JAN.	13.20	08
	b		30. Name and address of person		death (Item 23a) (Ty いろくい	pe, Print) Relined	ore au	w Ba	: Ikali	13.200	
	。 Sta Registr		31. Date filed (Month, Day, Gar,	0000 /21	trar's Signature	Relied					
	3		JAN 1 3	LUUU presignation	The same of the						

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-000/2 +	•	Please Type	or Print in t e of Maryland	d / Dona	delible in	K. Ensure Health and	Menta	pies Are Les L'Hygiene	gible.	
ank Smith		1- For State	e of Maryland		tificate of		ivienta		eg. No. 2 1	08 0066
Dhuria	i and	Registrar 1. Decedent's Name (First, Middle,L	ast)					2. Date of Dea	h	3. Time of Death
Physic edical Exam								Month January 3	Day Year , 2008	1358 hrs
Bear		4a. Facility Name (if not institution,	give street and numb	er)	41	. City, Town, or L	ocation of D		4c. County of De	eath
		St. Agnes Hospital				Baltimore			N/A	
Funera		Social Security Number 6.	Sex 7.	Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 2 Hours	4Hrs. 8. Date of Bit Min.	th(MM/DD/YYYY) 9.	reian
Directo	r	148-40-7092 1	X M 2 F	57	Yrs.	Months Days	Hours		-1950	Country) NEW JERSE
		Usual Residence of Decedent								10d. Inside City Limits
w any		10a. State 10b. County			Town or Location	ın				1 XYes 2 No
land f shor	ō	MD. N/A	<u> </u>	BA	LTIMORE	10f. Zip Code			0g. Citizen of What	Country?
Mary r 28a-	Director	10e. Street and Number 3308 FAIRVIEW	Δ17Ε ΔΡΤ	R		21216	;		USA	•
reath with the Maryland or items 23a or 28a-f show	=				C 13 W/20			? (Specify Yes or No		merican Indian, Black,
th with	Je ra	11. Marital Status 1 Never Married 2 Marr	12. Was Deced	es?	If Ye	s, specify Cuban,	, Mexican, P	uerto Rican, etc.)	White, et	
er death	by Funeral		1 Yes	2 No	1	Yes 2X No	specify:		Specify: [BLACK
irs aft	b y		or Dates:	completed)	16a. Decedent	s Usual Occupati	ion (Give kir	nd of work done	16b. Kind of Busin	ess/Industry
2 hou	ete	Elementary/Secondary (0-12)	College (1-4		during mo	st of working life.	DO NOT us	se retirea)	1	
036 within 72 iene. er than	Completed	-12-	-0-		DIS	ABILED M			US MAI	RINES
15-0036 filed within 72 hours I Hygiene. do other than "natur the Medical Fram	<u>5</u>]		Name (First, Middle,		
rk at a	B B	WILLIAM W. SMI			10h Meiling	Addross (Strop		ANCES R.	mber, City or Town,	State, Zip Code)
	<u>ا</u>	19a. Informant's Name/Relationship WILLIAM W. SM		OTHER)					JERSEY (
- P = E :		20a. Method of Disposition	111 JK. (BI			tion (Name of cer		Date	20c. Location - Ci	ty or Town, State
Baltimore, MD 2 cernit. Pages I and 2 shoul Department of Health and M Important: Item 27 is m		1 Burial 2 remation	3 X Removal from	n State	crematory or oth	er place)	ì	1 0 200	P A DATESTROI	IN NEU TEDCEV
ti Pag treent	5	4 Donation 5 Other Spe 21. Signature of Funeral Service Li	cify:							VN, NEW JERSEY
Baltim C permit. Page Department of		21. Signature of Fulleral Service El		liBi	1					JERSEY 08104
Physicia	_	23a. Part I Enter the disease, or co	omplications that cau	sed the death						
* /Medica	al	failure. List only one cause o Immediate Cause (Final disease	a. Sepsis							Death
xamine	T .	or condition resulting in death)	Due to (or as a c							
	Ι.	Sequentially list conditions,	b. Pneumoni			ct infect	ion			
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence o	11 J.					_ 69
/_ :	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence o	rf):					
executed an and	ical Ex		d							
D, be ex	edic	UNPENDED				ME.g876.	2/6/08	TT	23d. Date of de	elivery
376 ficate	s the	IF FEMALE: 23b. Was decedent pregnant in the		utcome of preg th		tal death 3	Ectopic	pregnancy	Month	Day Year
Box 68760, edeath certificate be enthe attending physicia	sician/Med	past 12 months?	4 Pregna	nt at time of de	=	her (Specify)			4	
Bo e deat	Phys	1 Yes 2 No 9 Unkr	9 Ulkilov				aliana in Dan	23e Did	tobacco use contribu	ute to the cause of death?
P.O. es that th										Probably 4 V Unknown
S, P.C	completed by	Cocaine use, h	ypertensive_	atherosc	teroric c	arutovasci	urar ur	24a. Wa	s an 24b. W	ere autopsy findings available
ord w req	nous 7					<u> </u>				or to completion of cause of ath?
Rec The la	page								2 V No 1	Yes 2 No
tal Rec cian: The certificate	director, page		Hospital:				Iou.	Check only one) Nursing Home 5	Residence 6	Other:
of Vital Records, ng Physician: The law require the this certificate has been si		1 Yes 2 No 27. Manner of Death	Hospital: 1 In		ER/Outpatient		ury at Work?		e how injury occurred	
n of ding Pl	tuneral	1 X Natural 5 Pendi	28a. Date o (Month,	Day,Year)	200. 1		Yes 2			
Sio Atten deatl	by the	2 Accident Invest	igation 28e Place	of Injury - At h	nome, farm, stre	et, factory, office	building, etc	28f. Location	(Street and Number	or Rural Route Number, City
Division tal or Attendir rs after death	filled in by the func	3 Suicide 6 Could determ	not be	, ,	,			or Town	, State)	
lospit 4 hour	- C	29a Certifier	ysician: To the best	of my knowled	dge, death occu	rred at the time, o	date and pla	ce, and due to the ca	use(s) and manner a	as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	completely	(Check only one) 2 Medical Exam	niner:On the basis of and manner sta	f examination	and/or investiga	tion, in my opinio	n, death occ	curred at the time, da	te and place, and du	e to the cause(s)
75 Wi 75	O N	29b. Signature and title of certifier		1		29c. Licen	se number			d (Month, Day, Year)
	X	Miles B	assoll	M		0.0	.M.E.		January 4, 2	2008
		30. Name and address of person					D 111	MD 04004		
1 of		Melissa Brassell, MD	Assistant Med			Penn Street,	Baitimore	e, IVID 21201		
-Dan	Stat	8 M 8 2 M 2	2008	gistrar's Signa	ture	A P				
Kec	istra	JAN 14	2.000 January	Card to the State	AN CONTRACTOR	4.5				

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Division or Vital Records, P.O. Box 6876000

		Plea For State Registrar	se Type or State o		nd / Depa	delible Inlartment of	Health	and N	-			006	68
Physicia		Decedent's Name (First, Middle Eleanor		nompson					2. Date of De Month Januar	Day	2008	3. Time of D	
/Medic Examin		4a. Facility Name (If not institution 132 Sherring	n, give street and nu			4b. City, Town,	or Location tonsv				ty of Death	e	
Funeral Director		5. Social Security Number 297–32–7032	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yr:	s. last birthday) 71 Yrs.	If Under 1 Yea Months Days		er 24 Hrs. Min.	8. Date of Bin (Month, Da Nov • 1	orth ay, Year) 0,1936	9. Birth Cou Ohic	place (State or ntry)	Foreign
n the Maryland r 28a-f show notified at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	imore	10c. C	Cat	cation Consville	<u> </u>			,		10d. Inside City	
with the I	I Director	10e. Street and Number 132 Sherring (54.0	10f. Zip Code	21228	3		10g. Citizen o	of What Cou	ntry?	
filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show snt, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ☑ Divorced	12. Was Dec Armed F ied 1 ☐ Yes	2€ No ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic C ban, Mexic	Origin? (Sp ean, Puerto	ecify Yes or No Rican, etc.)	В			
vithin 72 hou sne. than "natura se Medical E	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	st grade completed,) (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retii	ed) ed)	ost of work	ing	16b. Kind of	Business/Ir Home	dustry	
e d al	To Be Co	17. Father's Name (First, Middle, Harold Linste				iomeneo (C)	18. Mot		e (First, Middle	e, Maiden Surn		 	
and 2 shouealth and Mn 27 Is mai		19a. Informant's Name/Relations William Jeffrey	, , , ,		5770	ng Address (Stree) Thunde:	Hil	l Roa	d Colu	mbia, M	1D 210	45	
t. Pages 1 rtment of H rtant: If iter		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (S	pecify)	i State	letro Cr	esition (Name of matory or other potential)		1-1	1-2008	20c. Locatio	sville	, MD	
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	contracations that only one cause on a.		ath. Do not ent	Name and Add itzke fi 1555 Twir ter the mode of d	ing, such	as cardiac	or respiratory a		, MD 2	Approximate Interval Betwoonset and De	een
	dical Examiner	Sequentially list conditions, if any 1 leading to miscolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conse									
requires that the death certificate be een signed by the attending physicis nould be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome pf preg birth 2 Fe gnant at time of nown	etal death 3	□Ectopic pregnar □ Other (specify)				110	Date of delive		ear
w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause ç	iven in Par	t I.		tobacco use co Yes 2 □ No		the cause of de	
The law ate has b page 2 sl	Completed								24a. Was auto perl 1∐ Yes	opsy formed?	b. Were aut prior to co death? 1 ☐ Yes	opsy findings a ompletion of cat 2 ☐ No	vailable use of
hysiclan this certifi al director	To Be	25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 _	e of Injury	□ ER/Outpatier	II 3 L DOA	ther: 4 🗆			one) sidence 6 🗆		fy)	
il or Attending Physician: after death. I Director: After this certific in by the funeral director,	Certification:	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide determ	gation not be 28e. Place	nth, Day Year) se of injury - At ding, etc. (Spec	Injury home, farm, str cify)		Yes 2	□No		(Street and Nu own, State)	mber or Rui	al Route Numb	er,
To the Hospital or Al within 24 hours after d To the Funeral Direc completely filled in by	Medical C		ng Physician: To the Examiner: On the and ma										
To ti withi To ti	M	29b. Signature and title of certified Parks If	wharf	an		29c. Lice	nse numbe 247	81		29d. Date sig	ned (Month	, Day, Year)	
V		30. Name and address of person	ne H	eight	-5 A		BAL	10.	mt	2	122	9	
Sta Registra		31. Date filed (Month, Day, Year)	2008	Registrar's Sig	riatute								

			For State Registrar	State of Maryl		artment of F <i>rtificate of</i>			giene Reg. No.	4000	00669
Н	Dhoolai		1. Decedent's Name (First, Middle, La.	st)				2. Date of Dea			3. Time of Death
	Physici /Medic		GLORIA	J		TENSER		January		2008	1658 P M
	Examin	er	4a. Facility Name (If not institution, giv				or Location of Death		4c.	County of Death N/A	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.		h	9. Birth	place (State or Foreign
h	Director		210-20-7190	□ M 2 X F	77 Yrs.	Months Days	Hours Min.	02/16/1	930	NEW	Y O'RK
	rland ow at		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Le	ocation					10d. Inside City Limits
	Mary a-f she ified a	tor	MD N/A		BALTIM	ORE				1 NYes 2 N	
	ith the	Director	10e. Street and Number			10f. Zip Code		10g. Cit		zen of What Cou	•
	sath w s 23a nust k	eral	3041 FALLSTAFF F		5-11-0 40	Was Bassies of	21209	llVN		US 14. Race - Americ	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	I	was becoment of r if Yes, specify Cub 1 ☐ Yes 2 🕅 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.
15-0	יל 72 ה "natu edical	letec	15. Decedent's Ec (Specify only highest gra	lucation ide completed)	i (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kii	nd of Business/In	dustry
712	withir liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ine.	SALE	•			RETAIL	
nd	e filed al Hygi I other vent, tl	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nam		Maiden	Surname)	
yla	should be I and Mental I s marked or umatic eve	일	HENRY		TENSEF		FLORENCE			KOVENS	
	tra		19a. Informant's Name/Relationship (DAVID TENSER	/ BROTHER	2 HI	SHSTEPPER		BALTIMO	RE,	MD 2120)8
Baltimore,	permit. Pages 1 ar Department of Heal Important: If item 3 any Injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	Removal from State	HAAREI T	FILOH CO	NG. 01/1	3/2008	BAL.	TIMORE,	MD
Ball	permit Depar Impor any In once.		21. Signature of Funeral Service Licer		2	2. Name and Addre	_			& BROS.	
			23a. Part1. Enfer the disease, or com	plications that caused the	death. Do not en					ESVILLE,	, MD 21208 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.			,	, , , , , , , , , , , , , , , , , , , ,	,		Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as a con	sequence of):						2 days
Ē.	Examiner	_	Sequentially list conditions,	b. Cerebro		r disea	se				20 years
Т	nsit A lited	Examine	Sequentially list conditions, if any, leading to immediate caus. Ener Unit hypothesis (Cause (Disease or injury	Due to (or as a con	sequence on.						
o,	ortificate be executed ing physician and as the burial-transit	Еха	that initiated events resulting in death) Last								
68760,	ate be hysicii the bu	edical		.d							
	certific ding p		IF FEMALE:	23c. If yes, outcome pf pre	ananov						
P.O. Box	To the Hospital or Attending Physician; The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 1 4 Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		2	23d. Date of deliv Month	ery Day Year
S, D	ss that gned b		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
ord	require een si	ted	Ascending aurti	c aneurysm				1 🗆 \	/es 2[□ No 3 12 11 Prol	babły 4 Unknown
3ec	has b	Completed by	Coronary arte	ry disease	•			24a. Was autop		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
le l	in: Th ificate or, pag		25. Was case referred to medical				00 80	1 Yes	2 No	1 ☐ Yes	21 No
>	ysicia is cert directi	To Be	examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Deat			3 □Other (Speci	fv)
Division or Vital Records,	ng Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injui Wor		28d. Describe h			
Sio	ttendi death. ttor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be		\\ \hat{\tau} \\		Yes 2 No	2011			
Š	or Av	Certification:	4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp	at nome, tarm, sti pecify)	eet, factory, office		28f. Location (S City or Tow			al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, deat nination and/or in	h occurred at the tile evestigation, in my o	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens				e signed (Month,	
			Peter i. Cho	Surgeon		D41	1129		Jan	wary 10	, 2008
	10		30. Name and address of person who PETER W. CHO, N	completed cause of death (Item 23a) (Type,	Print) Baltimor	1129 re Balti	more 1	laryl	land 2	1215
12	Sta		31. Date filed (Month, Day, Year) JAN 1 5 2008	32. Registrar's S	ignature	₹ B					
DI	Registra	ali	2HIA T 9 5000	granist to 53	A STATE OF THE STA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-00182 Carl Lee Watkins	e ir	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		
Can Lee Watkins		1- For State Certificate of Death	Reg.	2008 0067
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Exami		Carl Lee Watkins, Jr.	January 7, 2	2008
(* 1:		4a. Facility Name (if not institution, give street and number) 207 Doris Ave. 4b. City, Town, or Location of Death Brooklyn		Anne Arundel
Funeral Director		5. Social Security Number 202-94-5992 1 X M 2 F F 29 Yrs. 4 Security Number 2 1 Security Number 2 1 Security Number 2 1 Security Number 3 1 Security Number 2 1 Security Number 2 1 Security Number 3	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
, i	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
l ow any		MD Anne Arundel Brooklyn		1 Yes 2 No
arylano Ba-f st	Director	10e. Street and Number 10f. Zip Code	1 "	g. Citizen of What Country?
the Ma or 2	Dire	207 Doris Avenue 21225	Ţ	Jnited States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
after (all', o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	· · · · · · · · · · · · · · · · · · ·	Specify: White
hours natur Exam	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/Industry
136 hin 72 e. than '	ple	12 Disabled		N/A
5-0036 led within 7 Hygiene. lother than	Completed	The distribution of the state o	ne (First, Middle, Ma	aiden Surname)
121; I be fil ental F arked vent, i	Be		Surwillo	
D 21 should and Mer	င္	June Knellinger - Mother 19b. Mailing Address (Street and Number or 207 Doris Avenue, Br		i i
and 2 shc fealth and traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or Town, State
nore ages l nt of l other		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Chaption 5 Wother Specify: West Arundel Crematory 1-	14-2008	Odenton, MD
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Funer Service Licence 22. Name and Address of Facility Am	brose Fur	neral Home, Inc.
Per De li ii.	1	2719 Hammonds Fry	Rd., Lar	nsdowne, MD 21227
Physician M i I	3 33	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	st, shock, or heart Approximate Interval Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death) a. Fentany 1 intoxication Due to (or as a consequence of):		
(Sequentially list conditions, b.		
	iner	if any, leading to immediate Due to (or as a consequence of):		
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	_	d.	<u> </u>	
6 be expected by the second points of the second po	edic	AMENDED #23a,27,28a-f, perME,g875, 1/19/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
68760, certificate be nding physic	cian/Medical	23b. Was decedent pregnant in the next 12 months?	nancy	Month Day Year
Box 6 e death ce the attend ed for use	S	1 Yes 2 No 9 Unknown		
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut After this certificate has been signed by the attending physician and timeral director, page 2 should be detached for use as the burial - tran	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to the cause of death?
, P.(res tha signed be det	d by		1 Yes	2 No 3 Probably 4 Unknown
rds v requi s been should	Completed		24a. Was a autops	sy prior to completion of cause of
Che lav	omp		perfor 1 V Yes 2	
of Vital Records, Jing Physician: The law requir After this certificate has been s funeral director, page 2 should I	Be C	25. Was case referred to medical 26.Place of Death (Crec		
F Vit	Tol	examiner? 1 V Yes 2 No 27. Manner of Death Phospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nur 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other: Scene
noluga Idinga h. : Afte	ion:	1 Natural 5 Pendias (Month, Day, Year) 1 Yes 2 Y No	unk	10.1. mga y 2000.1.00
Division tal or Attendi rs after death.	ertification	2 Accident Investigation PIRC 1/1/2005 FIRC 4:04 all 1 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Rural Route Number, City
Div bital or bral Di	erti	3 Suicide 6 X Could not be determined (Specify) other scene	or Town, S 207 Doris	s Ave. Brooklyn, MD
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Puneral Director: After this certif completely filled in by the funeral director,	calC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the caus	e(s) and manner as stated.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 29c. License number	at the tille, udte	29d. Date signed (Month, Day, Year)
	2	290. Signature and title of certifier O.C.M.E.		January 7, 2008
		30. Name and address of person who completed cause of death (Item 23a)		<u> </u>
vo 1				

State Registrar DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

Zabiullah Ali, M.D. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

OCME

ORIGINAL

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

> State Registrar

DHMH 17 Rev 1/2001

3001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

BAHL

ES 0001

S. HANOVER STREET BALTIMORE.

JANUARY, 06, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4a. Facility Name (If not institution, give street and number) January Wilson, Sr /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner er i Year | If Under 24 Hrs. s Days Hours Min. 8. Date of Birth 9. Birthplace (State Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 225-26-6869 1 M M 2 □ F Director death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No imore **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than asol 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Addless (Street and Numbe Informant's Name/Relationship (Type. item 27 i Method of Disposition permit. Pages
Department of
Important: If it
any injury or o Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Nat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 1-0-14-/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Unsease or injury that initiated events resulting in death) Last r-umon. Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown by 23e. Did tobacco use contribute to the cause of death? cate has been signed to page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2∏ No 3 ☐ Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy certificate 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1_Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29085 Jenuery 13

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.-Registrar's Signalure

Chinci

J-

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		partment of Health and I Certificate of Death		g. No.	006/3
Phys		Decedent's Name (First, Middle, Last) Carraus	Welch		2. Date of Death Month January	10, 2008 Year	3. Time of Death 4:25P M
/Me Exan	dica! niner	4a. Facility Name (If not institution, give sta Baltimore Washingto		4b. City, Town, or Location of Death		4c. County of Death	3.1
Funer	al al	5. Social Security Number 6. Sex.	7. Age (In yrs. last birthd	av) If Under 1 Year If Under 24 Hrs.		Anne Aruno	place (State or Foreign
Directo		492-30-9439 1 4	M 2□F 88 Yrs	Months Days Hours Min.	March 10	(ear) 1919 Coui	MS MS
yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			0d. Inside City Limits
he Mai	ector	MD Anne Aruno	del Glen Bur		140	035	1 Yes 2 No
h with	Dir	10e. Street and Number 425 Wellham Avenue		10f. Zip Code 21061	1	g. Citizen of What Cour • S • A •	iuy:
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumstic event, the Medical Examiner must be multified at	by Funeral Director	11. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Afr American	
within 72 ho ane. then "natur	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	scedent's Usual Occupation live kind of work done during most of wor e. DO NOT use retired) ply Officer	rking	6b. Kind of Business/In U.S. Army	dustry
e filed al Hygid cother vent, II	Be Co	17. Father's Name (First, Middle, Last)	Sup		me (First, Middle, Ma		
2 should be and Mental Is marked c	To	Att Welch 19a. Informant's Name/Relationship (Type	- Printl	Hallie Audress (Street and Number or Ru	en / Courte Alumba e	City or Town State 7in	Cadal
and 2 shealth and m 27 ls n		Mrs. Elizabeth C. I		Wellham Avenue Gl			(Code)
Pages 1 and the source of the		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State cemetery,	a '	. 16,	Oc. Location - City or To	
그는만큼	- SUCE	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Sinservices 1 2nd Avn	ngleton F	Crownsville uneral & Cr en Burnie,	remation
		23a. Part1. Erner the disease, or complications shock, or heart failure. List only one	ations that caused the death. Do not				Approximate Interval Between Onset and Death
Physicia /Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	long fail	ure.		
ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	DENOTAR.			
ath cert attendin for use	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
n requires that the de been signed by the a should be detached	2	Part II. Other significant conditions control	ributing to death but not resulting in th	e underlying cause given in Part I.		acco use contribute to to	he cause of death?
: The law re- cate has bee , page 2 sho	Completed				24a. Was an autopsy performs	prior to co	psy findings available mpletion of cause of 2 No
ysicien s certif director	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	spital: 1 Inpatient 2 ER/Outpa	Other	ath <i>(Ch</i> eck only one, Iome 5 ☐ Residen	ce 6 □Other (Special	iv)
ding Phy th. After thi funeral	tion: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Injur	e of 28c. Injury at	28d. Describe how		,,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	i Route Number,
e Hospit 24 hours e Funera letely fille	edical C	29a. Certifier (Check only one) Certifying Physic Medical Examine	cian: To the best of my knowledge, d pr: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
To th within To th	Me	29b. Signature and title at certifier	e M	29c. License number 7 00405		d. Date signed (Month,	
Y	D	30. Name and address of person who com		pe, Print) Parlison Porle C	elen Bu	1-10-	1067
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:45 AM 11, 2008 Rebecca Jean Woods January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edgewood Harford 1201 Hanson Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2√2 F Yrs. Director Dec. 20, 1957 Maryland 50 220-74-6032 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show than "natural", or items 23a or 28a-f shov he Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Hanson Road 21040 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the I Owner / Operator Handicap Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Robert Kenneth Smith Lillie Mae Combs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is ı James M. Woods / Husband 1201 Hanson Rd., Edgewood, MD 21040 Department of Healt Important: If item 2 any injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 1-14-08 Bel Air, Maryland 21. Signature of Fun Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUSCULAR DYSTRUPMY **Physician** OYEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSINGETIVE LUNG 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an cate has by page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 2 D0056296

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Noods, Prebecco

State Registrar SouthAtwoodRd. Suite 206 Beldig, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Part of the state of

Tason Birnbaum M.D. 602.
Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH.g875, 1/18/08 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12, 4:30 P M 2008 January Margarete (nmn) Wessel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 21, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 378-50-6375 375-50-6375 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F 75 Germany Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 21040 USA 2100 Bayberry Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2/☑ No Maryland 21215-0036 Specify: þ White 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) / Operator Cosmetology 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Fritz (unk) Preisser Rosa (unk) (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2953 Margate Ct., Abingdon, MD 21009 <u>Sue Ann Emberton / Daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-15-08

22. Name and Address of Facility
McComas Funeral Home, P.A. 1-15-08 21. Signature of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MESENTERIC ISCHEMIA JUPERIOR Physician DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, SEVERE Supply 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. 24 hours after death Pruneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D1056296 cause of death (Item 23a) (Type, Print) 30. Name and ad less of person who complete 500 Upper Chesapeake Drive Bel Air, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

1 2008 5 JAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] 8

For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician ANUARY 11:36 AM BLANCHF WORMSER EDOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RANDALLSTOWN NORTH WEST TOCPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 MD Date of Birth Month 30/1920 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 N F Months 87 Yrs. 212-16-2275 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County r than "natural", or items 23s or 28s-f show tre Medical Examinar must be notified at 1 Tyes 2 No OWINGS MILLS BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21117 4730 ATRIUM COURT APT. #179 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event potes. Be ROSENFELD IDA GREENBERG SAM ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 PACERS LANE, BALTIMORE, MD EDWARD SHAIVITZ / SON 20a. Method of Disposition
1 ☑ABurial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/13/2008 BALTIMORE, MD BETH TFILOH CONG. 4 □ Donation , 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner VOLVULUS SIGMOI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events physicien and resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical igned by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√3No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No certificete 1 ☐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\triangle \text{Residence} \) 6 \(\triangle \text{Other} \((Specify) \) 1 ☐ Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54352 2008 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOT OLD COURT RUAD RANDALLSTOWN HOSPITAL 21133 NO PITH WEST 32, Registrar's Signature 31. Date filed (Month, Day, Year) State 5 JAN 100 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar	•	rtment of F <i>tificate of</i>			iene eg. No.	
	Physicia		Norman Howard Norman Howard Norman Howard Norman Howard					2. Date of Deat Month 01	000	3. Time of Seath 1 3 10:55PM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Se	ex ▼ M 2□ F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Bii	thplace (State or Foreign ountry)
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	death with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	MD Baltim 10e. Street and Number 409 Alabama Roac		Towson	10f. Zip Code	.204	1	0g. Citizen of What C	ountry?
8 P 2 3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 【X Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			Hispanic Origin? (S ean, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	te, etc.
15-0036	in 72 hours "natural", '-di-al Exa	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest grad	Year or Dates: ucation de completed)	I (Give	dent's Usual Occup kind of work done OO NOT use retire	during most of wor	rking	16b. Kind of Business	White s/Industry
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	f and 2 s fealth an em 27 is	_	Susan Zerofsky/k	life	409	Alabama	Road, To	wson, MD	21204 20c. Location - City o	
ansary Baltimore,	Pages tment of I tant: If ite		1 ☐ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specify</i>	Removal from State Du	cemetery, crei Ilaney Indens	natorý or other pla lalley Me	:	1-16-2008	Timoni	um
Jan	Departition Departition Departition Departies and Departies and Departies De		21. Signature of Funeral Service Licen	Luci		TO20 10L	K Rodu,	TOWSOH, I		
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the dea one cause on each line.		er the mode of dyi		c or respiratory arr	rest,	Approximate Interval Between Onset and Death
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	and transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse						
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fsk.	quires that n signed b	by	Part II. Other significant conditions o	ontributing to death but not re	esulting in the u	nderlying cause gi	ven in Part I.		_	to the cause of death? Probably 4 □Unknown
erofs!	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed						24a. Was a autop perfor	an 24b. Were sy prior to death? 2 No 1 Ye	
Z Z	ysician: nis certific director,	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpatient 2 [□ ER/Outpatie	nt 3□ DOA Ot	har:	ath <i>(Check only of</i> Home 5□ Resid	ne) lence 6 Other (Sp	pecify) Hospice
Division or	tending Pheath. tor; After the funeral	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be			M 1	Yes 2 No		ow injury occurred	Pural Pouta Number
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Com-	the Hosp in 24 hou the Fune ipletely fi	Medical	(Check only 2 ☐ Medical Examone)	ysician: To the best of my kr niner: On the basis of examin and manner stated.		nvestigation, in my	opinion, death occ	curred at the time,	date and place, and d	ue to the cause(s)
	To T COT	Σ	29b. Signature and title of certifier	y Nely	in	9 D2	Se number		29d. Date signed (Mo	12, 2008
	(10)		30. Name and address of person who	completed cause of (Ite	em 23a) (Type,	Print)	hales	St. Bo	lto ma	12,7008
	Sia Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nafure					

DHMH 17 Rev 1/2001

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			1	For State Registrer	State	of Ma	•		artment of H		d Mental H	ygiene Reg. No.		00678		
	Phy	/siciar		Decedent's Name (First, Middle ABRAM	Last)	ZILBERMAN					2. Date of D Month		2008	3. Time of Death		
		ledica amine		4a. Facility Name (If not institution,	give street and	number)		LDE	4b. City, Town, or	r Location of De			County of Death	pm		
				JEWISH CONVAL				h . d	BALTIMO	RE	ire I a Data of B		BALTIMOR			
	Fund Direct			5. Social Security Number 213-47-7325	6. Sex 1 Ø M 2 ☐ F		e (In yrs. last birti 84	naay) (rs.	Months Days		1rs. 8. Date of B lin. (Month, 2 07/10/	irth Day, Year) 1923	BEL	place (State or Foreign ntry) ARUS		
	and	2	-	Usual Residence of Decedent 10a. State 10b. County			10c. City, Town	or Lo	cation					10d. Inside City Limits		
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	death v	1879	Funeral Director	3601 FORDS LAN			Ever in U.S.	13.	Was Decedent of H	215 Hispanic Origin?	(Specify Yes or N	10-	USA 14. Race - Ameri			
	36 s after or Itan	Na direct	y Fun	1 Never Married 2 Marri	ad 1 □Ye If Yes,	s 2 🔼 N Give	No		fYes, specify Cuba 1 □ Yes 2 🛣 No	an, Mexican, Pu Specify:	ierto Rican, etc.)		Black, White, Specify: WH			
	-00.	cal Ex	led by	3 X Widowed 4 □ Divorced 15. Decedent	15. Decedent's Education 16a. Decedent's Usual Occupation							16b. Kind of Business/Industry				
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	/lan	rtic av	o Be	JOSEPH			ZILBER	MAN		LUBA			STRELC	IN		
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an	Baltimore, Department of Hea Mportant: If Itam	or othe	-	20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal fro	m State	cemeter	y, crei	sition (Name of matory or other place	· 1	Date		ocation - City or T			
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berm	68760, A	the br	dical		d											
1	Box 68 sath cartificat attending phy	use a	In/Me	tF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetal death	3[Ectopic pregnancy	,			23d. Date of deliv	,		
S	O. B the deat y the att	hed for	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pr		time of death		Other (specify)	y 			Month	Day Year		
	b that if	detac	ny Pn	Part II. Other significant condition	ns contributing to	o death b	ut not resulting in	the u	nderlying cause giv	ven in Part I.	23e. Did	d tobacco u	use contribute to	the cause of death?		
	ords equires	d bluo	ted b	End rles	n d	em	enhe	_ '	-		1	Yes 2	□No 3□Pro	bably 4 Minknown		
	Reconse law r	ge 2 sh	Completed								24a. Wa	as an topsy normed?	prior to co	opsy findings available ompletion of cause of		
	ital	stor, pa		25. Was case referred to medical						26. Place of	1 ☐ Yes Death (Check only		1 Yes	2 🗆 No		
	of V Physic this ce	al direc	0	examiner? 1 Yes 2 No 27. Manner of Death		☐ Inpatie				4 Nursin	-		6 Other (Spec	ify)		
	ion or noting lath.	e funer	atlon	Natural 5 Pending	28a. Date of Injury Inding Injury Injury 28b. Time of Injury Injury 28c. Injury at Work? Injury M 1 Yes 2 No					200. 2630110	28d. Describe how injury occurred					
	Division of Vital Records, to Attanding Physician: The law requires tatler death. Director: After this certificate has been signa	in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	fospital thours a unaral l	ely filled		29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										stated. to the cause(s)		
Oivision Official Records, Downs after death cardinal physician: To the Hospital: Ond Signal A Scription Ond Signal A Scrip							ated.	29c. License number				29d. Date signed (M		, Day, Year)		
	F 5 F	0		> Oluy 9	MW)			741	4817	·	JK	m- 11	-2008		
		1		30. Name and address of person v	who completed c	ause of d	leath (Item 23a) (Туре,	Print)	. 0	e arre		Relhd	Lone		
		State	e	31. Date filed (Month, Day, Year)	32	. Registr	ar's Signature		40000			Qu.	12121	Demonth— Dem		
	Re DHMH 17 Re	gistra		JAN 15	2008	Top Set	- B-A	Service .	262							

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toto	of I	Maryla	nd / D	enartment	of H	ealth	and	Mental	Hygien

2008 00679

exter Lafrance Ash		d State of Mary	land / Department o <i>Certificate</i> o	if Health and IV If Death	ientai riygi	Reg. N		00 000
	Rec	istrar Decedent's Name (First, Middle,Last)		, Bodin	2.	Date of Death		3. Time of Death
Physician/ Medical Examiner		exter	L.	Ashfor		Month Da January 12, 2	800	0044 hrs
	4a	Facility Name (if not institution, give street and	number)	4b. City, Town, or Local	ation of Death		4c. County of Death Baltimore Cou	
-, /		406 Shirley Manor Rd. # B2		Reisterstown	f Under 24Hrs.	Date of Birth/N	IM/DD/YYYY) 9. Bir	
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. last birthday)		Hours Min		Foreig	gn puntry) TN
Director	1	215-15-7529 1XM 2	F 37 Y	rs.		06 28	70	
		ual Residence of Decedent	10c. City, Town or Loc	ation				10d. Inside City Limits
w any	10	a. State 10b. County		erstown				1 Yes 2 X No
fand frsho once.		MD Baltimore e. Street and Number	Keist	10f. Zip Code		10g.	Citizen of What Cou	untry?
the Maryland a or 28a-f sh tiffed at once	10		-	2113	0.6		ri S A	
ith the		306 Bryanstone Roa Marital Status 12. Was		Mac Decedent of Hispar	nic Origin? (Spec	cify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
r death with or items 23 must be no	1	Never Married 2 Married Arme		f Yes, specify Cuban, M	exican, Puerto K	ican, etc./		Black
0 9 2 E	_ 3	Widowed 4 Divorced If Yes, Give	Year 1	Yes 2X No s		14	Specify: 6b. Kind of Business	
5-0036 cle within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by I		5. Decedent's Education (Specify only highest	during	lent's Usual Occupation most of working life. D	(Give kind of wo O N OT use retire		JD. Ring of Eddingos	
72 ho		Ziomona, J. Zi	ge (1-4 or 5+)	iness Cor	ngultan	ı+	Veri	zon
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau			rs Bus	18	.Mother's Name (First, Middle, Ma		
filed v all Hygis ed other t, the	3 1	7. Father's Name (First, Middle, Last)			Cora Du	pree		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		Milton Ashford Ja. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street a	and Number or Ru	ural Route Number	er, City or Town, Sta	wn, Ma
MD 2 id 2 shou ilth and M m 27 is n aumatic	- '	Cora Ashford-Mothe	er 306	Bryanst		ad, Rei	20c. Location - City	or Town State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iften 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2	Da. Method of Disposition	oromoton/ O	position (Name of ceme r other place)				
lore ages I nt of I t: If	- 1	A Building 2 Contraction 2	val from State St. I	Lukes	1/19	9/08	Randall	stown, Md
Baltimore, permit. Pages I an Department of Hea Important: If itel	1	1. Signature of Funeral Service Licensee	2	2. Name and Address of	of Facility			_
Ba perm Depri inju	(Forme H. 1/h				. Balti	more, M	d 21215 Approximate Interva
Physician	1	3a. Part I. Enter the disease, or complications failure. List only one cause on each line.	hat caused the death. Do not ent	ter the mode of dying, s	uch as cardiac or	respiratory arros	.,	Between Onset and Death
edical	١	mmediate Cause (Final disease a. Dia	betic ketoacidosis					
Immer		or condition resulting in death) Due to (o	r as a consequence of):					
:		Sequentially list conditions, fany, leading to immediate Due to (c	r as a consequence of):					l
	드	course Enter Underlying Cause	or as a consequence of);					
sd sait	ЕХа	events resulting in death) Last Due to (c	r as a consequence or,					
	edical		DED 075 1	/17/00 गग				
O, e be e ysiciai burial		220	DED Sa, 27, perME, g875, 1 f yes, outcome of pregnancy	/1//08_11			23d. Date of deli	
ords, P.O. Box 68760, v requires that the death certificate by seen signed by the attending physic should be detached for use as the but	Physician/M	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	Live birth 2	Fetal death 3	Ectopic pregna	ancy	Month	Day Year
X 6	ξį	1 Yes 2 No 9 Unknown g	Pregnant at time of death 5	Other (Specify)			8	5 × 70 × 1
Bone dea	چ	Part II. Other significant conditions contrib		the underlying cause g	iven in Part I.			e to the cause of death?
P.O.	by	rait ii. Other significant content				1 Yes		Probably 4 V Unknown
S, F	ted					24a. Was		e autopsy findings availat r to completion of cause o
Cord law rec has bee	Completed						med? dea	
Rec The la icate h	팃			26 Place	of Death (Check		2	
tal Rec	Be	25. Was case referred to medical examiner? Hospital	1 Inpatient 2 ER/Outp	atient 3 DOA			Residence 6	Other: Scene
Vit hysic r this	P	1 ✓ Yes 2 No	inpedent 2		ry at Work?	28d. Describe	how injury occurred	
ding Ph		1 X Natural 5 Pending	a. Date of Injury (Month, Day,Year)	1	Yes 2 No			(Particular - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 -
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	2 Accident Investigation	se. Place of Injury - At home, farm	n, street, factory, office t	ouilding, etc.	28f. Location (or Town,	Street and Number	or Rural Route Number, C
Jivis N or / Safter I Dire	THE PERSON	Suicide 6 Could not be determined (5	Specify)			or rown,		
E 2 5 E		4 Homicide		occurred at the time, d	ate and place, ar	nd due to the cau	se(s) and manner a	s stated.
To the Hos within 24 hd To the Fun completely	edical	one) Medical Examiner: On the	the best of my knowledge, death basis of examination and/or invi- anner stated.	estigation, in my opinion	n, death occurred	at the time, date		
To 1 With To com	Med	29b. Signature and title of certifier	ELINO: Stated.	29c. Licen	se number		29d. Date signed	(Month, Day, real)
		auoto.		O.C	.M.E.		January 12,	ZUU0
		30. Name and address of person who comple	ted cause of death (Item 23a)			04		
			dical Examiner 111 Pe	enn Street, Baltim	ore, MD 212	U ⁻ I		
01		Ana Rubio MD. Assistant Me 31. Date filed (Month, Den (Par) 1 6 20	32. Registrar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ENA 2008 L015 01 /Medical 4a. Facility Name (If not institution, give street and numb 4c. County of Death 4b. City, Town, or Location of Death Examiner LAUREL PRI NOE LAUREL REGIONAL HOSPITAL "G-EORGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1939 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🔀 F 68 N. CAROLINA 241-60-8462 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No MD HOWARD COLUMBIA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or ? must be r 6513 OUIET HOURS 21045 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK þ 3 Widowed 4 Divorced "natural" Completed er than "natur , the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN JANITORIAL 9TH Department of Health and Mental Hygis Important: If item 27 Is marked other is any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 CROSBY LILES CLARA HOLLIDAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNADETTE BELL / DAUGHTER 6513 QUIET HOURS, COLUMBIA, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State MEADOWRIDGE MEM. PK 01/18/08 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Syneral Service Licensee 10220 GUILFORD ROAD, JESSUP, MD 20794 23a. Part Enter the diserse, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h and failure. List only one cause on each line. Immedi. le Cur se (Final disease) condition a. METASTATIC **Physician** METASTATIC LUNG CANCER resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE Completed SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed' ATRIAL FIBRILLATION WITH RAPID VENTRICULAR PATE 25. Was case referred to medical examiner? 1 Yes 2 No Be (26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be 3 ☐ Suicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director: / within 24 hours a To the Funeral I

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1900/ Glandower Rd, GaiThy Surg, MD 20579 RANGANATAAH ANTHI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

d

Medical

0 0 5 8 2 3. Time of Death

/Medica	ı
Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

ian cal	PETER BRISCOE			JAN. 15	, 2008	4:30 A ^M
ner	4a. Facility Name (If not institution, give street and number)	-	4b. City, Town, or Location of Death		4c. County of Death	
	ALICE MANOR NURSING HOME		BALTIMORE CITY		N/A	
	5. Social Security Number 6. Sex 7. Ag 12 M 2 □ F 7. Ag	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 5/10/192	ar) 9. Birthpl UNKn	ace (State or Foreign try)
	Usual Residence of Decedent	10c. City, Town or Lo	ention		11	0d. Inside City Limits
ō	10a. State 10b. County N/A		ALTIMORE CITY		11	XXYes 2 □ No
rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
Ö	2095 ROCKROSE AVENUE		21211		USA	
Completed by Funeral Director	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
F	Armed Forces? 1 Never Married 2 Married 1 Yes XX If Yes, Give	No.	1 ☐ Yes XX No Specify:	nican, etc.)		ACK
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			40		
lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	. Kind of Business/Ind	lustry
F	Elementary/Secondary (0-12) College (1-4or 9)+)	LABORER/TRUCK LOAI		ARMING CO.	•
Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mai	den Surname)	
10 E	UNK		UNK			
	19a. Informant's Name/Relationship (Type. Print)	195 Maili BAL	PIMORE CITY COMIS	SION ON A	ity or Jown, State, Zip GING	Code)
	ARTIE SHAW / LEGAL GUARDIAI	20b. Place of Dispo	N. CALVERT STREET,		E, MD 2120 Location - City or To	
	20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place)		TONSVILLE	
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Paneral Service Licensee ✓	METRO CRI	2. Name and Address of Facility HC		· · · · · · · · · · · · · · · · ·	, MID
	21. Signature desprieral service Licensee	/ .	1600 LIBERTY HEIGH			MD 21207
	23a. Par Int. the sease, or complications that caused short, or eart ailure. List only one cause on each li		Committee of the Control of the Cont			Approximate Interval Between
	Immediate Lause (Final	Candir	or hearns			Onset and Death
	disease or condition resulting in death) a Due to (or as	a consequence of):	(C mount			
	Sequentially list conditions	Sepsis				
iner	Sequentially list conditions, if any leading to firmediat cause. Enter Underlying Cause (Disease or injury	a consequence of):				
Examiner	that initiated events c.	a consequence of):				
교 田		,,				
edic	d					
N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		⊒Ectopic pregnancy		23d. Date of delive	,
/sician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a		Other (specify)		Month	Day Year
Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death b	ut not resulting in the	inderlying cause given in Part I	23e Did tohan	co use contribute to the	ne cause of death?
b	Phostato Cances		domontia	1 ☐ Yes	2 No 3 Prob	/
Completed by	The same same	O. V V ,	der and	24a. Was an	24h Wara auto	psy findings available
ם				autopsy performe	prior to co	mpletion of cause of
	25. Was case referred to medical		26 Place of Dea	1 Yes 2√2 th (Check only one)	No 1 □Yes	No
To Be	examiner? Hospital:	ent 2 ☐ ER/Outpatie	Other:		e 6 □Other (Specif	iv)
	27. Manner of Death 28a. Date of Inji 11 Natural 5 □ Pending (Month, De	ury 28b. Time o	of 28c. Injury at Work?	28d. Describe how	injury occurred	
atio	2 Accident investigation	, , , , ,	M 1 ☐ Yes 2 ☐ No			
iệi E		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
Ce	29a. Certifier 1 Certifying Physician: To the best	of my knowledge dea	th occurred at the time, date and place	and due to the caus	se(s) and manner as s	tated.
Medical Certification:	(Check only 2 Medical Examiner: On the basis one) and manner st	of examination and/or in	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	o the cause(s)
Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
	EM, Pgr		64493	0	1-15-21	200
	30. Name and address of person who completed cause of completed cause of complete cause of ca	leath (Item 23a) (Type	Print Front #30	& Ball	imana	ma alani

State Registrar 3 Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 5:15 PM M 2008 January 11, /Medical Edna Lee Boyd 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖼 F 83 Director WV 08/21/1924 <u>234-32-2898</u> 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medkal Examiner must be notified at 1 ☐ Yes 2 K No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20904-Funeral 2501 Musgrove Rd 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Law Office Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F Blanche DeMoss Charles Thomas Boyd 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Elsie S. Riley/Friend 6605 Well Parkway Hyattsville, MD 20782permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Jan 14 4 Donation 5 Dother (Specify) Chesapeake Crematory Beltsville, Maryland 2008 21. Signature of Funeral Service 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BRONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Probably 4 Unknown PERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? /es 2 No HROME OBSTRUCTIVE TILLMONARY 1 ☐ Yes 2 No NISEASE 1□ Yes Division or Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient မ 3□ DOA this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter t Certification: or Attending Injury 5 Pending М investigation 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled Fo the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RICHARD NGUYEN MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** A M 4:40 Baby Boy Bell JANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Jan 5, 20 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1**∏** M 2□ F Months Days 16 Maryland Director none Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1530 N. Carey Street 21202 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify black 3 Widowed 4 Divorced Year or Dates: Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Thomasena Bell ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5₩Other(Specify)in state 21. Sig Letur of Euneral Serv Ronal S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PREMATURITY EXTREME 136 minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, he will be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse juence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2XNo 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform certificate 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27, Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MD D66161 2008 erson who completed cause of death (Item 23a) (Type, Print) 5T. 3 ZYMANSKI BALTIMORE. 21287 LINDA 600 N. WOLFE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

1 - For State Registrar 1. Decedent's Nar

To Be Completed by Funeral Director

Physician

/Medical

Examiner

Funeral

Director

Physician

Physician/Medical Examiner

State Registrar		•	Certificate (of Health and of Death		No. Con.	8 00485
Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day Y	3. Time of Death
DOROTHY M. BLANKENSH	IIP				JANUARY 10		7:30 P M
. Facility Name (If not institution, gi	ive street and number)		4b. City, Tov	vn, or Location of Deat	h	4c. County of	Death
ARINER HEALTH OF NO		- //	44.75	N BURNIE ear If Under 24 Hrs	8. Date of Birth	ANNE ARU	
	Sex 7. Age	e (In yrs. last birth 90 Yı	Months D	ays Hours Min.		'ear)	Birthplace (State or Foreign Country)
sual Residence of Decedent	XX	50			DONE 22, 13		TID .
a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 HNo
MD ANNE ARU	JNDEL	GLEN BU	IRNIE				
e. Street and Number			10f. Zip Co	de	10g	. Citizen of Wha	at Country?
313 HOSPITAL DR.	T		210			USA 14 Page	American Indian,
. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent B Armed Forces?		if Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)		White, etc.
Widowed 4 Divorced	If Yes, Give Year or Dates:	10	1 ☐ Yes 💥	No Specify:		Specify:	WHITE
15. Decedent's B	l Education		Decedent's Usual O			b. Kind of Busin	
(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5		life. DO NOT use n	lone during most of wo etired)	rking		
8			WAITRESS			RESTAURA	NT
. Father's Name (First, Middle, Las	st)			18. Mother's Na	me (First, Middle, Ma	iden Surname)	
JOSEPH BURKHARDT		100	Antibon All Anti-	ELLA ROSE		34	-1- 7:- O- d-)
a. Informant's Name/Relationship KEN SNOWDEN	(Type. Print)			reet and Number or R D. D 75 JESSU			are, <i>2ip Code)</i>
a. Method of Disposition 1 Burial 2 Cremation 3	□Romoval from State		Disposition (Name of crematory or othe		Date 20	c. Location - Cit	ty or Town, State
4 □ Donation 5 □ Other (Spec		BAYVIEW	CREMATORY	INC 1.14	.2008	BALTIMORE	, MD
. Signature of Funeral Service Live	ensee		22. Name and A	ddress of Facility			
IL. GREGORY FINK	Jana L	M01148		ERAL HOME, P.		1061	
	mplications that caused	the death. Do no	426 CRAIN of enter the mode of	FRAL HOME, P. HWY S. GLEN f dying, such as cardia	BURNIE, MD 2		Approximate Interval Between
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Medical Certification: To Be Completed by 29a. Certifier (Check only one) 29b. Signature and title of certifier handolivet Hy 29d. Date signed (Month, Day, Year) 29c. License number 00029873 Dhy sician 10 Name and address of person who completed gause of death (Item 23a) (Type, Print) PITAL DR., GLEN BURNE, MA 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Donald William Bish 01 14 2008 19:13 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air, Maryland
Under 1 Year | If Under 24 Hrs. | 8 Harford 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F Director 215-30-7862 12/01/1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Fallston Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ral", or items 23a or Examiner must be r U.S.A.
1 14. Race - American Indian, 1100 Mill Creek Road Funeral 21047 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces (
1 Myes 2 No
If Yes, Give Korean
Year or Dates: Conflict
16a, I 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 Superior Carriers Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland 2 should be finance and Mental F Be Carroll W. Bish Gladys L. Schwarz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann S. Bish (wife) 1100 Mill Creek Road - Fallston, Maryland 21047
f Disposition (Name of Date 20c. Location - City or Town, State Department of Heal Important: If item 2 any injury or other Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/18/2008 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland as saln 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Physician /Medical Due to (or as a consequence of): Examiner CmV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-tra Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed's Vital 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 00063420 January 14,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 500 upper Chegaparke Dr. Bel Air, MD 21014 Kharal -ubair 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 Registrar

Pm

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State of Maryland / Department of Health and Mental Hygiene Floring State Registrar Amend 19b, perFH, g875 1/16/08 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3:10 pm C. Joan Bender January 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/23/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 173-36-4227 1 □ M 3€XF 59 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at MD Montgomery Silver Spring 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 14000 Castle Boulevard Apartment 20904 310 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 M Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical other traumatic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward D. Bender Martha S. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 131 Parliament Place, Pittsburgh, PA 16101 15236 Rose Bender / Sister Department of Health a Important: If item 27 is any injury or other tra once, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition parial 2 □Cremation 3 MRemoval from State 1/14/2008 Greenwood Cemetery New Castle, PA 16101 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licenses Mow Show 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypoxic Cardiopulmonary Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Intra Cerebral Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events Box 68760, 2 resulting in death) Last Due to (or as a consequence of): Physician/Medical the as attending I for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an Hypotension page 2 s autopsy performed' 2 **X** No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21K No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gartifier D 0064100 January 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Smitha Bhikkaji, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEW/8 9 105 10e f 11 12 15 20 22 per H C8751/18/08 WS

State of Maryland / Department of Hearth and Mental Hygrene. 1- State Registrar Amend #6, perAB, 0875, 1/16/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 4:15 A M 2008 Frances Bartow 01 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner GOOD SAMARITAN BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Octooth, Day, Yea Jan 12, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. -153 M 2\□F Hours Months Days Director 86 220-18-7924 MD. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1√ Yes 2 No MD Funeral Director Baltimore Baltimore City 10e, Street and Number **5900 Winthrop** 10g. Citizen of What Country? 10f. Zip Code Avenue If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be USA death 12. Was Decedent Ever in U Sunk | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent Origin? (Specify Yes or No-Armed Forces) | 14. Was Decedent Ori unk Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify: white Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unkd 2 should be filed within 7, th and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) unk 12yrs. Artist unk 2yrs. Maryland 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) -unk-Be Pages 1 and 2 should ပ Arthur S. Herman, Sr. Sarah Cunningham 19b. Mailing Address (Street and Number or Fural Floute Number, City or Town, State, Zip Code)

4637 River Overlook Dr. Valrico, Florida 33596

5601 Loch Roven Blvd Baltimore, MD 21239 19a. Informant's Name/Relationship (Type. Print) Arthur S. Herman III (Nephew) t of Health Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, Metro Crematory 1/15/08 4 □ Donation Stother (Specify) in Stoth Balto. MD. 21. Signature of Euneral Service Licensee Ronald 5 Wa 22. Name and Address of Facility Lassing Rueral Home Baltimore, 7401 Pelair Rd. Paltimore, Mil. m nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cax e (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner CLOSTRIDIUM DIFFICILE COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1

Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö within 24 hours a

To the Funeral I To the Hospital 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. RES 000 01/06/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J BALTIMORE 5601 LOCHRAVEN BLVD. MD 21239 SHAMS QUAZI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 16 . Registrar

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cia lica ine	rtifica	te has been signed by the attending physician and	111	Sie	4	Important; If Item
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	1 - For State Registrar			d / Depa		Healt	h and N		giene Reg. No. 2 (008	006	89
ysician Medical kaminer	1. Decedent's Name (First, Midd LOBERT 4a. Facility Name (If not institution Shady Grove H	on, give street and numb		scoon	ABERG 4b. City, Town Rocky		ion of Death	2. Date of Dea Month JANUAR	Y 06 4c. Coun	Year 2008 ty of Death	3. Time of Do	
neral ector	5. Social Security Number 212-24-4025 Usual Residence of Decedent		. Age (In yrs. la	**	If Under 1 Yes	ar If Un	ider 24 Hrs. Irs Min.	8. Date of Birt (Month, Da Jan 16,	h	9. Birthp	lace (State or F try) h Carol	-oreign Lina
be notified at	MD Montg 10e. Street and Number 5314 Manorfie	omery		Town or Lo	10f. Zip Code	20853	.		10g. Citizen o		0d. Inside City 1	
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce	12. Was Deced Armed Force 1 XYes 2 If Yes, Give Year or Date	es?	4		f Hispanic uban, Mex lo <i>Spe</i>	Origin? (Sp kican, Puerto	ecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, ify: whi	etc. te	
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er traumatic e	Abe Edwin Blo 19a. Informant's Name/Relation Phyllis Bloom	nship (Type. Print)	:	ı	-	et and Nu	ımber or Rui	verman ral Route Numbe Rockvil	-	n, State, Zip		
injury or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (21. Signature of Funeral Service	Specify)	CO	emetery, crei	sition (Name of natory or other p 2. Name and Ade	trace of E	acility	Date	20c. Location			
s the burial-transit and leading leadi	3a. Pan Enter the dis lase, shock or heart fail Ire. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (ras a consequence CARD ras a consequence ENDST	ence of): 10 12 Es chec ut): A Q E ence of):	PIRATOR RENAL	LOPP 27 DISC	FAILU	URE	rrest,		Approximate Interval Between Onset and De	en ath
detached for use as the Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregna Other (specify,				1	Date of delive Month	ery Day Ye	ar
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	Part II. Other significant condi	tions contributing to dea	ith but not resul	lting in the u	nderlying cause	given in P	art I.	1 □ ` 24a. Was autop	Yes 2 No an 24tosy	3 Prob	ne cause of dea pably 4 □Un psy findings av mpletion of cau	nknown /ailable
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ompletely filled in by	29a. Certifier 1 ☐ Certify	ing Physician: To the base and manner	sis of examinati	vledge, deat	vestigation, in m		, death occu	rred at the time,	cause(s) and	e, and due to	the cause(s)	
OO	Mama and address of person	n who completed cause	of death (Item		DO Print)	062	562		JANUA	RY 01	2008	
State egistrar	31. Date filed (Month, Day, Yea JAN 1 6	r) 32. Re	1901 M gistrar's Signat	ure	L CENT	UK I		ROCKVIL	CG M/	TICTORY	0 203	,,,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death william **Physician** 00 P M ANUARY 2008 /Medical unty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Yown, or Location of Death Examiner hospital andall fown alno (enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days 80 MD **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. Specify: 31ack 3 Midowed 4 ☐ Divorced other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Overnite Incorporate Truck Driver 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bradlei Elmor ulia John son 19a. Informant's Name/Relationship, (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Windsor Mill MD 21244 Stuart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Divings Mills, MD 25.08 Forest Garrison 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral SYCS Vaughn Road Kandallstown MD 8728 Liberty 23a. Part1. Enter the a sease, or complications that caused the death shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, wich as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Marner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Accident Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler Medical (Check only one) title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature an lician Hanvary On O 2008 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) nospitoh VVERAHALLI HARISH. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND TIPM/20 Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:31PM BUTLER EMMA JANYARY 13 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Se AUD 5. Social Security Number 7. Age (In yrs. laşt birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Min. 1 □ M 2 F 212-34-1200 December 10,1929 Director irginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notifled at Baltimore 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4025 Frederick Avenue, Apt. 105 21229 States United permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Ex miner must any Injury or other traumatic event, the Medical Ex miner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Club Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LLKKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
302 South Collins Avenue Baltimore, MD. 21229 Kurman Kobinson-Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD. Metro Crematory 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 27 Name and Address of Facility Funeral Home, P.A. Brary P. March Funeral Home, P.A. 270 Fredhilton Pass Baltimore, 23a. Party Enter the prease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart liture. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RLA LUN PNUEMONIA MD. 21839 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CHRONIL OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ARTERIOSCIEROTIC HEART physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADRENAL MASS 1 Yes 2 No 3 Probably 4 1 Unknown Completed HYPERTENTION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23300 JAN WARY 13 2008 BON SELOURS PRUCPITA2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL. SUDMIRA 2000 W. BAZTU STO 13A2TO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 ZUUO

			for State Registrar	State of Maryla		artment of F rtificate of			eg. No.	08	00692
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Louis L. I	•				Jan 7,	2008	Year	3. Time of Death 4:18 P M
	Examin		4a. Facility Name (If not institution, give Southern Maryla			4b. City, Town, o	or Location of Death		4c. County		George's
	Funeral Director		370 40 3343	ex 7. Age (In yrs	iast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 28	, Year) 1932	9. Birthp Coun Wash	lace (State or Foreign htry) nington DC
000	show 1 at	_	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
Mod	Ba-f s	Director	Maryland Prince (George's E	orrest	T					1 ☐ Yes 2 ☐ No
4	a or 2 be no	ä	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W		
400	is 23	eral	2709 Lakel	nurst Ave	IS 13)747 Henanic Origin? (Spe	acify Vas or No.	United		an Indian,
OCOO	permit. Fages I and 2 should be the writin 72 nours are regent with the maryland permit. Fages I and Kential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed • • Divorced	Armed Forces? 1 TYYes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes XXNo	dispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)		k, White,	
5 3	natura Ilcal E	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Bu	siness/Inc	dustry
7	ne. han "ı e Med	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	Line		during most of work d)	,,,9	Pepco 1	F1 oct	-ric
7 7	Hygier Hygier Hertl nt, th	ပိ	17. Father's Name (First, Middle, Last)		Line	liaii	18. Mother's Name	/First Middle I			,1 1 C
מוופ	antal h	9 Be	_ ` ` _ ` '	ce Beavers				et Mary		<i>-</i> ,	
11 y	md Me mark math	은	19a. Informant's Name/Relationship (19b. Mailii	ng Address (Street	and Number or Run			State, Zip	Code)
M	alth a		Monica M. Haley	- Pierson	250	L1euelyn	Lane, Hur	tingtow:	n, MD 20	0639	
บ์ วั	of He fitem		20a. Method of Disposition	Pamayal from State	Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	wn, State
JIIII.	ment ant: It		1 ☐ Burial 2√13 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	/)			Jan 10,		Clinton		
	Depart Import any Inj once.		21. Signature of Funeral Service/Licer	MD1464			ess of Facility Lee a Ferry Ro				
			23a. Frt1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause of each ine.	ath. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a House M	yocard	nal Inte	within				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	guence of):						
s Š		ē	Sequentially list conditions,	b. Due to for as a consc	quenes of):						-
To de	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
5	an an an an irial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
covou,	inicate be executed ig physician and as the burial-transit	edical		d							
D. DOX O	To the hospinal or Attenuing Frigstrain. The law requires that begin benincate by executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Dati Moi	e of delive	ery Day Year
, T.	ned by detac	0	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contr	ibute to th	ne cause of death?
COLUS,	quires in sign	ed by						1 □ Y	es 2⊒No	3 🗌 Prob	pably 4 □Unknown
	aw re is bee 2 sho	Completed						24a. Was a	n 24b. V	Vere auto	psy findings available mpletion of cause of
94	ate ha	Com						autops perfori 1□ Yes	med?	leath?	2⊟No
rien.	entific ector,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	ne)		
5 Phys	this o	ျှ	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 €	≥ER/Outpatier 28b. Time o	IL 3 DOA		me 5 Reside			у)
2 5	h. After funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2□No	28d. Describe ho	ow injury occurr	ea	
I VI OI	ter deat irector: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		l home, farm, str sify)			28f. Location (Si City or Town	treet and Numbe n, State)	er or Rura	al Route Number,
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Hoe	24 ho 24 ho e Fun letely	edical		niner: On the basis of examir and manner stated.							
Total	within comp	Me	29b. Signature and title of portifie			29c. Licens	se number	2	29d. Date signed	i (Month,	Day, Year)
)			> xan	MB		200	55120	J	TAnnay 8	200	8
	6		30. Name and address of person who				- 0	F 3:			
	-01		31. Date filed (Month, Day, Year)	32. Registrar's Sign	enne JE	. thate S?	D Washing	wn DC	20032		
	Sta Registr		JAN 1 6 20	08 A Second	S. Again	ACT D					

Registrar DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

State Registrar 30. Name and address of person who

Year)

31. Date filed (Month, Day,

completed cause of death (Item 234) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible I State of Maryland / Department of Certificate of Strate	of Health and Mental H			8 0069	5
ecedent's Name (First, Middle,Last)	· · · · · · · · · · · · · · · · · · ·	Date of Death Month Day	Year	3. Time of Death 1712 hrs	
Sharon Grace Becker		Month Day January 8, 2008		17121115	j
Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. (County of Death)	
5302 McKinley Street	Rethesda	Mo	ontaomerv		

Registrar		Ce	ertificate d	oi Deal	111			Reg. N	No.	
Physician/ 1. Decedent's Name	e (First, Middle,Last) on Grace I	Becker					2. Date o Month Janua	f Death	v Vear	3. Time of Death 1712 hrs
	f not institution, give st		-	4b. City, Beth	Town, or Lo	ocation of			4c. County of Death Montgomery	
		7. Age (In yrs.	last hirthday)		ler 1 Year	If Under	24Hrs. 8. Date	of Birth (N	/M/DD/YYYY) 9. Birt	hplace (State or
Director			/ 1	Mont	_	Hours	Min.	•	Foreig	nMinnesota
474-80-30 Usual Residence of	07	2 X F	41 Y	rs.			Aug	ust 2	3,1966 co	y/
	10b. County	10c. City	, Town or Loc	cation						10d. Inside City Limits
<u> </u>	Montgome	ry Be	thesda							1 Yes 2 X No
5-0036 Fed within 72 hours after death with the Maryland of the what was the death with the Maryland of the the Medical Examiner must be notified at one other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at one other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at one of the Medical Examiner mu					Code				Citizen of What Cour	
the motified with the M with the M with the M with the M 11. Marital Status 1. Marital Status 1. Marital Status	Kinley Str	ceet 2. Was Decedent Ever in U	J.S. 13 V		20814		n? (Specify Yes		nited Stat	tes can Indian, Black,
The state of the s	ed 2 X Married	Armed Forces?					Puerto Rican, etc		White, etc.	,
— ja ja di didowed	4 Divorced If	Yes 2 X No	1	Yes 2	X No	specify:			Specify: Bla	ck
yd b 15. Decedent, s Eq	or	Dates: nighest grade completed)		lent's Usua	Occupatio	n (Give kir	nd of work done	16	b. Kind of Business/I	
15. Decedent's Ed	ndary (0-12)	College (1-4 or 5+)	during	most of wo	orking life. [OO NOT us	se retired)			
21215-0036 Ould be filed within 72 Ad Menul Hygiene, a marked other than " ic event, the Medical in event, the Medical in 19a". In 19a" in 19a		5+		Tea	acher				Educat	ion
17. Father's Name (First, Middle, Last)		•		18	8.Mother's	Name (First, Min	ddle, Maid	len Surname)	
Stanley Stanley	Melvin Be						ine San			
Stanley Stanley Stanley Stanley Stanley Daniel	me/Relationship (Type		4		`				, City or Town, State	
	V. Becker	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~							, Marylan	
20a. Method of Dispose I am of the Heal of	X Cremation 3	Removal from State	Place of Disp crematory or				Date January		Oc. Location - City or	rown, State
Page 1 Donation 5	Other Specify:		ntgomen	ry Cr	emato	rium	2008	I	Bethesda,	Maryland
Department of Her Department o	neral Service Licensee		22	. Name and	d Address o	of Facility	Robert A	A. Pu	imphrey Fu	neral Home,
(Anita)	for Brown		$\frac{11}{8}$	nc./Be ethese	etnes da, M	da-Un aryla	nevy Cha Ind 2081	se, /	337 Wisco	nsin Avenue
	e diseáse, or complica ly one cause on each	tions that caused the deat line.	h. Do not ente	r the mode	of dying, s	uch as car	diac or respirato	ory arrest,	shock, or heart	Approximate Interval Between Onset and
aminer Immediate Cause (F		ardiac arrhythm								Death
or condition resulting	.g in death) Due	e to (or as a consequence	of):							
Sequentially list cor if any, leading to im		e to (or as a consequence	of):							
if any, leading to im cause. Enter Unde (Disease or injury a events resulting in o	iar initiared	e to (or as a consequence	of\:	_						
	death) Last Due	e to (or as a consequence	O1).							
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O Tag Spare Spart II. Other signif	No 9 🗸 Unknown	Pregnant at time of d	leath 5	Other (Sp	ecify)			_	cco use contribute to	the cause of death?
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		-	For State Registrar	State of Ma	ıryıan	•		nt of He te of D			ental Hy	giene Reg. No.	200	8	00	696
Phy	sicia		1. Decedent's Name (First, Middle,	Last)							2. Date of D Month	eath Day	Ye	ear		of Death
/M	edica	al .	Paul Bec				41. 62	_			Tenum.		2 000		414	2 ~ M
Exa Fune Direc	_		4a. Facility Name (If not institution, 5. Social Security Number 219-18-6693	Huga-tel	(In yrs. 85	last birthday) Yrs.	Ro	r, Town, or I		o cum	8. Date of B (Month, D	B	County of I	ma	ace (State	or Foreign
P.			Usual Residence of Decedent		10- 04	T								140	al lestale	Oltre Limite
anylar show		7	MD BALT	IMORE		y, Town or Lo		C						10		City Limits es 2 No
the M		Director	10e. Street and Number	INUKE		OWINGS		p Code				10a. Citiz	zen of Wha	t Count		
ath with s 23a or		ial Di	6 NOBILITY COUR						21117				USA			
ges 1 and 2 should be filed within 72 hours after death with the Maryland to the Health and Mental Hygiene. If I them 27 15 manked other than "natural", or items 23a or 28a-f show nor other than "natural", or items 23a or 28a-f show the transmitte bean other than "natural".		by Funeral	11. Marital Status 1 □ Never Married 2 → Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 TYes 2 N If Yes, Give Year or Dates:			was Deci If Yes, sp 1 Yes		Specify:		cify Yes or N Rican, etc.)			White, e	tc.	
within 72 hc ane. than "natul		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	+)	16a. Deced (Give life. i	kind of w DO NOT I	ual Occupa ork done di use retired) SALESI	uring mos	st of workir	ng	ř.	nd of Busin		,	
filed v Hygie			17. Father's Name (First, Middle, L.	ast)			•			er's Name	(First, Middle	1		_0111	ING	
buld be filed with Mental Hygiene. arked other than aric event the N		o Be	HARRY			BECKER			MI	INNIE			H	ORNS	TEIN	
2 should and N is main		-0-	19a. Informant's Name/Relationshi	(Type. Print)		19b. Mailir	ng Addres	ss (Street a	nd Numb	er or Rura	l Route Num	ber, City or	r Town, Sta	ite, Zip (Code)	
1 and 2 Health em 27		8	RITA BECKER /	WIFE	Took F			ry col	JRT,				MILL			21117
Pages 1 nent of H	5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (<i>Spi</i>		ANS	Place of Dispo SHE ^{ery} EM TZ CHA	UNPAYH"	other place	"		/2008		cation - Cit	•		
permit. Page Department of Important: If	ë	1	21. Signature of Funeral Service Li		<u> VI</u>			and Addres			L LEVI					
	티		Koluto 1	d						LOMN	ROAD -	PIKE		.Е ,	MD 2	1208
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused nly one cause on each lin	the deat e.	h. Do not ent	er the mo	de of dying	ı, such as	cardiac o	r respiratory	arrest,			Approxim Interval E Onset an	letween
Physici /Medio	_		Immediate Cause (Final disease or condition resulting in death)	a. Accuma Due to (or as a			-0-1	/	~~	rus	a tro	~				
Examin							~ -	1-5	-							
70 5		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseq	uence of):	,							I.		
ficate be executed physician and sthe hurial-transit		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	conseq	uence of):										
be eg		<u>ё</u> Ш		30.0 (0.00		201,00 0.,.										
tificate g phys		edical		0.												
The law requires that the death certificate be executed the has been signed by the attending physician and hand 2 should be detached for use as the burial-transit		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Feta	al death 3	∃Ectopic ∃Other (s	pregnancy specify)				2	23d. Date o Month		y Day	Year
ires that the de signed by the a			Part II. Other significant condition	s contributing to death bu	it not res	ulting in the u	nderlying	cause give	n in Part I	i.	23e. Did	tobacco u	se contribu	ute to the	e cause o	of death?
w requires been sign		ed by									1	Yes 2[]No 3[Proba	ably 4	nknown
le law re has bee	1	Completed									24a. Wa	opsv	24b. We	re autop	sy finding	gs available f cause of
The cate h	n i	Con									per 1∐ Yes	formed?	dea	ıth?	2DNo	
ician;		Be	25. Was case referred to medical examiner?	Hospital:				Othe		e of Death	(Check only	one)				
Phys	5	<u>۱.</u>	1 Yes 27 No 27, Manner of Death	28a. Date of Injur		ER/Outpatier 28b. Time o		28c. Injury Work	4 🗆 191		ne 5 ☐ Re 28d. Describe			(Specify)	
Attending Physician: The street of the stree		tion	1 Natural 5 Pending 2 Accident Investiga	(Month, Day	Year)	Injury	М		? ′es 2 🗌				,			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica compalety filled in by the funeral director.		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At h	ome, farm, str fy)	eet, facto	ory, office		2	28f. Location City or T	(Street and own, State	d Number (or Rural	Route N	umber,
e Hospit 24 hour e Funera		Medical (Physician: To the best of xaminer: On the basis of and manner sta	examina											e(s)
To the To the Compo		Me	29b. Signature and title of certifier				2	9c. License	number			29d. Dat	te signed (/	Month, L	Day, Year)
			cenque					0	29	08	5	70~	U C- 7		3 2	008
(0			30. Name and address of person w										•	2	, 4	
Y	Stat	e	31. Date filed (Month, Day, Year)	32. Registra		4(C)	C .	n ca	- ح ب ن	+ 1	2000			21	13-	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:28 PM Emelia 01 2008 14 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimure
If Under 24 Hrs. Samaritan pital tos Good 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Qountry) 7. Age (In yrs. last birthday) 1 Year Days 5. Social Security Number 6 Sex **Funeral** Hours 1□ M 28 F largland 217-20-F282 Usual Residence of Decedent Director 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 TYPS 2 No Baltimore Director ud. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. A. 21212 626 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 To No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black Ď 3 PWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 200K 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Antonio Thomason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto. important: if item 27 ie eny injury or other trat QDCB. led. Tunbridge Lowe 626 Koland harles 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1-18-2008 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Congestive heart failure Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of) Severe Cardiom o ath that initiated events resulting in death) Last Due to (or as a consequence of): ai re on chronic rena insu icienc Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Malnutrition 24a Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

inding physicien and use as the burial-translt Division of Vital Records, P.O. Box 68760, been signed by the s should be deteched page 2 s After this certifice funeral director, p filled in by the ft within 24 hours efter To the Funerel Dire

is marked other then "naturel", or tems 23s or 28s-f show sumatic event, the Medical Examinar must be notified at

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Maryland 21215-0036

bert Baltimore,

> **Physician** /Medical Examiner Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOUC MD 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21239 Loch Raven Boulevard Baltimore FANG YIN 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1:32 2008 Zeloa Chester /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year Λι 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral Min. Hours 1 M 2 1 Months Davs Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? esourceA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2□No þ 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last) College (1-4or 5+) cler 18. Mother's Name (First, Middle, Maiden Surname, Be Watkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Old 20b. Place of Disposition (Name of cemetery, crematory or other place).
Garrison Twest Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 01/24/03 DWINAS Mills. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugun C. Greene Turned Sins Signature of Funeral Service Licenses any ndacoster, mo 21133 728 Liberty Pd. 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initialed events resulting in death) Last trelu-Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 1 ☐ Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2/2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3□ DOA မှ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

certificate be executed physician and s the burial-trans as attending I ed by the a Division or Vital Records, P.O. signed t neec has , page this certificate the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After completely filled in by the funeral

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

Department of Health Important; If item 27

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3altimore, Maryland 21215-0036

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

21133

State Registrar 31. Date filed (Month, Day, Year) 2008 6



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** January 8, 2008 7:30 AM M Richard Vincent Culter Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Holly Hill Manor If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Sept 7, 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 90 1917 Director 562-14-6763 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #318 20 S. Charles Street 21201 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Porces:
1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 40-44 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard V. Culter Florence Learbs 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 S. Charles Street #318 Baltimore, MD Richard B. Stofberg/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronal d 21201 Baltimore, MD nn Part1. En. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** chronic obstrictive disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed P.O. Records, Vital Attending Physician: 9 Division after death Hospital or within 24 hours a

To the Funeral I

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the attending physician

has

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filed within 72 hours after death with the Maryland

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

at Hygiene.

permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked or

Baltimore,

Injury or other traumatic

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 16

29c. License number

301

Towson

29d. Date signed (Month, Day, Year)

and manner stated.

402 York

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

and shoot

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death = State Registrar Amend #2, per DVR, g875, 1/16/08 TT Reg. No. 2008 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2007 1:20p **Physician** 14 01 Commodore Julia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 607 Pennsylvania Ave Apt 104 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2√2 F 25 MD Yrs. 02 17 90 213-20-0129 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland 10a State 10b. County items 23a or 28a-f show ner must be notified at X□Yes 2□No Baltimore Directo NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 14. Race - American Indian, Black, White, etc. Ave Apt 104
Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 [X] No
If Yes, Give
Year or Dates: 21201 Funeral 607 Pennsylvania Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black altimore, Maryland 21215-0036 "natural", or NUMBER NOT SEEN NOT 9 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If flem 27 is marked other the any injury or other traumatic event, the once. the NA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Weeden Fred Wesley Matthews ပ 19a. Informant's Name/Relationship (Type. Print)
Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 5010 Corley Road, Apt B3, Baltimore, Cheryl Commodore-Daughter 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 1/25/08 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Licent March F/H West 21215 4300 Wabash Ave, Baltimore, Md tume Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAPDIAL NITHPETTON **Physician** HOUTE /Medical Due to (or as a consequence of): **Examiner** HYPET-TONSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPET CHOUSTEPOLEMIA that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical the phy as attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death nse 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 PNo ed by the a o. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t or Vital Records, ð 1 ☐ Yes 2 🖼 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No has page 1 ☐ Yes 2 No 1∏ Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Physician: funeral director, Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 24 No ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 2 ☐ Accident 5 Pending investigation Division 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier 80 NOE4

Registrar

DHMH 17 Rev 1/2001

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WASHINGTON

Name and Idress of person who completed cause of death (Item 23a) (Type, Print)

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32. Régistrar's Signature

WINSTON

JAN 16

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Jannie 6:00 A M Tahuary 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore If Under 1 Year I If Under Keswick Nursing Home 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗗 🖡 Yrs. Director 85 17 SC Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 3902 North Rogers Ave 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ Xo Specify Specify: Black þ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' 9th grade College (1-4or 5+) Care Taker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Ray L. Terry <u>Marie Patton</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If Item 27 any injury or other tra once. Kenny Abrams-Great-Nephew Smith Mill Road, New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 1/19/08 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death I medi Cause (Final di eas or condition re ul g in death) Left middle cerebral wifery **Physician** 5 months /Medical Due to (or as a consequence of): Examiner Chronic afrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnent 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ disease Coronare 2 No 3 Probably 4 Unknown 1 Tes Completed Carally 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2**□** No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 12,2008 D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIBBLE THEFREGOR, 700 W HOK Sheet, Balquire, Md 21211 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

JAN 16

08-00390	
Hubert Coffey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Hubert Coffey		State of Maryland / 1- For State	Department of Certificate of			. 200	18 0070
Physic	ian/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death	. No. <u>C. U.</u>	3. Time of Death
Medical Exam		Hubert		Coffey	Month January 13	Day Year , 2008	2230 hrs
		Facility Name (if not institution, give street and number) Johns Hopkins Bayview	4	b. City, Town, or Location of De Baltimore City	eath	4c. County of Dea	ith
Funera		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24		(MM/DD/YYYY) 9. E	
Director		241-56-2297 1X M 2 F	74 Yrs.		Min. 02 1	7 33 Fore	Country) NC
'n	1	Usual Residence of Decedent					
ом апу		· ·	0c. City, Town or Locati				10d. Inside City Limits 1 X Yes 2 No
yland F show a	ţ	MD NA 10e. Street and Number	Balti				21
11987 r death with the Mary or items 23a or 28a must be notified at	Director			10f. Zip Code	10	g. Citizen of What Co	
SEL! 1 with the Maryland ms 23a or 28a-f sho be,notified at once,	a D	4108 Rollins Ave	vor in II S 12 War	21207 s Decedent of Hispanic Origin?	/ Specify Ves or No	U.S	• A • erican Indian, Black,
eath w	Funeral	1 Never Married 2 X Married Armed Forces?	If Ye	es, specify Cuban, Mexican, Pu		White, etc.	erican indian, black,
fler d	۱ >	3 Widowed 4 Divorced If Yes, Give Year	No 1	Yes 2 X No specify:		Specify: B	lack
5-0036 led within 72 hours a tygiene. other than "natura"	Completed by	15. Decedent's Education (Specify only highest grade compl	leted) 16a. Decedent	's Usual Occupation (Give kind		16b. Kind of Busines	s/Industry
6 172 h an "n ical E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use	,		
within giene.	l m	12th grade na 17. Father's Name (First, Middle, Last)	Se	curity		Harbor H	ospital
	Be C				ame (First, Middle, M	aiden Surname)	
Z. = 0 0 2 5	ہ ا	Henry Coffey 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number	ie Pace or Rural Route Numb	per, City or Town, Sta	ite, Zip Code)
e, MD I and 2 sho Health and item 27 is	15	Cecelia Coffey-Wife	4.0	Rollins Ave		•	21207
ages I and 2 shount of Health and N		20a. Method of Disposition	20b. Place of Disposi	tion (Name of cemetery,		20c. Location - City	or Town, State
MOI Pages ent of ent: It		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		Forest Vet	1/25/08	Owings	MTlls. Md
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	l y	21. Signature of Funeral Servic- Licensee		ame and Address of Facility		0 11 21 19 0	
© § § ©	ne si	23a. Part I. Enter the disease, or complications that caused the	Sun 43	00 Wabash A	ve, Balt:	imore, M	d 21215
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not enter th	e mode of dying, such as cardi	ac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of):				
	Examiner	(Disease or injury that initiated events resulting in death). Last					
ansit	<u>x</u>	events resulting in death) Last Due to (or as a consequence of the con	derice or).				
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Box 68760, e death certificate be the attending physic ed for use as the buri	Se l	IF FEMALE: 23c. If yes, outcome	perME_G876 of pregnancy	<u> 2/4/08 TT</u>		23d. Date of deliv	ery
tox 6876 eath certificate at the light of th	Physician/M	23b. Was decedent pregnant in the past 12 months?	₂ Fet	al death 3 Ectopic pre	egnancy	Month	Day Year
OX eath c atten for us	/sic	1 Yes 2 No 9 Unknown g Unknown	ne of death 5 Oth	ner (Specify)			
D. B t the d by the		The state of the s	out not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ires that the signed by	db	Hypertensive atherosclerotic c	ardiovascular	disease:	1 Yes	2 No 3 P	robably 4 🗸 Unknown
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be Wer this certificate has been signed by the attending physici meral director, page 2 should be detached for use as the build meral director, page 2 should be detached for use as the build but the state of the page 2 should be detached for use as the build but the state of the page 2 should be detached for use as the build but the state of the page 2 should be detached for use as the build but the state of the stat	Completed by	Chronic renal insufficiency			24a. Was a		autopsy findings available
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ing Ph After I uneral	ᇤ	27. Manner of Death 28a. Date of Injury	28b. Time of Ir	ijury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
vision or Attendin fter death. Director: A in by the fu	Certification:	1 X Natural 5 Pending 2 Accident Investigation	"	1 Yes 2 No			
	tili	3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, stree	t, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Spine or nours after filled in	Cer	4 Homicide determined (Specify)					
To the Hospitel within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my k (Check only one) 2 Medical Examiner: On the basis of examiner					
To II comp	Medical	2 whether Examiner on the basis of examiner and manner stated. 29b. Signature and title of certifier	and and or investigati	29c. License number	os at the time, date a	29d. Date signed (A	
		Mal A. II now	\	O.C.M.E.		January 15, 20	
Ja,		Meling Glassey, Me	th (Itom 22a)	J. J. J. J. J. J. J. J. J. J. J. J. J. J			
D 1		30. Name and address of person who completed cause of dea Melissa Brassell, MD Assistant Medical E	,	enn Street, Baltimore, N	/ID 21201		
S	tate		Signature				
Regis		IAN 1 6 2008	I South				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January hyllis 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death LATIMORRE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-3-1963 Birthplace (State or Foreign Country) (In yrs. last birthday, Hours Days 1 □ M 2√2 F 216-80-1619 44 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √Yes 2 No Baltimore MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 305 W. 23rd Street IJ S A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ PYes, Give Year or Dates: Never Married 2 Married 3 Widowed 4 Divorced 2 □ No 1 ☐ Yes 2 ☑ No Specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Unk Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Colbert, Sr Annie M. Gundy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD21218 23rd Street Balto, 305 E. Norman Colbert - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 1-18-2008 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East North Avenue Balto, MD 21202 1101 Ε. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory great shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lue to (or as a consequenc of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy perform 2 No 26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation

that the death certificate be executed and Box 68760, P.O. Records, peen certificate has The or Vital After this Division death.

burial-transit attending physician for use as the buria the as signed by t page or Attending Director: / hours after within 24 hours at To the Funeral D the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

notified

item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r

12 should be filed within 7 h and Mental Hygiene. **7 is marked other than** "r

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Physician

/Medical Examiner

and 2 should

Baltimore, Maryland 212

Director

Funeral

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Completed

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Examiner

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide

6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed, (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

abatableian

8/2008

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MIDI

DHMH 17 Rev 1/2001

		Please Type or Print in Black Indelible Ink. Ensure Al State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	lental Hygie	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Hilda A. Crouch	2. Date of Death Month January	Day Year 3. Time of Beath 12 2008 5:09p
Examin Funeral Director	-	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 219-26-6600 1 M 2 M 2 M 69 Yrs. Months Days Hours Min. M	8. Date of Birth (Month, Day, Y Feb. 8, 1	4c. County of Death BALTIMORE
le Maryland Ba-f show stified at	Director	Usual Residence of Decedent 10a. State MD Baltimore 10c. City, Town or Location Middle River		10d. Inside City Limits 1 ☐ Yes 2 💆 No
ath with the 23a or 23uust be no		10e. Street and Number 1216 Susquehanna Avenue 10f. Zip Code 21220		, Citizen of What Country? USA
72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examiner must <u>be notified at</u>	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Jones.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Homemaker	ing	sb. Kind of Business/Industry
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and 2 sho alth and h 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Alfred L. Crouch /husband 19b. Mailing Address (Street and Number or Run.) 1216 Susquehanna A		
Pages 1 ament of He ant: If Item ury or oth		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1X Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 1/	/16/08 E	oc. Location - City or Town, State Baltimore MD
permit. Depart Import any inj once			al Home	e of Essex 21221
Physician /Medical Examiner pnuial-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		t, Approximate Interval Between Onset and Death
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v requires the been signer should be d	ρ	ARDS		cco use contribute to the cause of death?
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ng Phys ffer this ineral dii	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be 388. Rises of injury At home form street factors of figure 1.	28d. Describe how	ce 6 □Other (Specify) injury occurred et and Number or Rural Route Number.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 ☐ Homicide building, etc. (Specify) 29a. Certifier 1 ✓ ertifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Town,	State) Ise(s) and manner as stated.
To the Hi within 24 To the Fi completed	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month, Day, Year)
6		30. Name and address of person who completed cause of leath (tern 23a) (Type, Print)	Marke	1-13-2008 BABUGIEME 25T-Stesso 2120
Sta Registra	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		0, 3,(3,0214)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Amend Item 23a per dr., g875, Q1/16/108dlab Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** MARGARET TANVARY CURREY 5,2003 14:26 Pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. HARBOR HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-56-4582 1 □ M 2 □ F 57 **Director** Feb.12,1950 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Director Baltimore 1 □Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Iner must be n 1524 Cypress Street "natural", or items 23a death v 21225 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by 3 ☐ Widowed 4 € Divorced the Medical E 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Bookkeeper 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brooklyn Progressive realth and Mental Hygis m 27 is marked other th er traumatic ever 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Herman Diesel Margaret Glode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Jones /daughter : If item 27 i 8540 Harris Avenue Parkville MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 1/7/08 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 remation 3 Removal from State permit. Page Department or Important: If any injury or Baltimore MD 4 Donation Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature ral Service License Connelly Funeral Home of Essex 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiorgan WEEK /Medical Due to (or as a consequent of) Examiner Septic shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WEEK Examiner The law requires that the death certificate be executed End Stage Renal Disease 6 years Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 2 1 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending 24 hours after death e Funeral Director: filled in by completely within 2 To the I



State

Registrar

JEGAIEHU 31. Date filed (Month, Day, Year)

M. D

29a. Certifier

(Check only one)

29b. Signature and title of certifier

TEREFE CALFA WOSSEN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

JANUARY 05,2003

HOSPITAL, 3001 S Hanovei Strift

08-00271 Derrick J. Clark, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 00706

			ate of Death		د U U ی. No.	0 0070					
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death					
/ledical Exam	ıner	Derrick James Clark, Jr. 4a. Facility Name (if not institution, give street and number)		January 9,	2008	2028 hrs					
		Baltimore Washington Medical Center	4b. City, Town, or Location of Deat Glen Burnie	n	4c. County of Death Anne Arundel						
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birt)		s 8 Date of Birth		holace (State or					
Director	218-71-8088										
ıny	Director	Usual Residence of Decedent 10a. State	or Location			10d. Inside City Limits					
d hows											
Maryland 28a-f show any d at once.		Maryland Anne Arundel Sever 10e. Street and Number	10f. Zip Code	10-	g. Citizen of What Coun	itry?					
ith the Maryland 23a or 28a-f she notified at once	Dir.	7962 Telegraph Rd.	21144		Jnited Stat	96					
with ns 23; be not	ral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ						
death rriter nust l	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.						
rs after ural", o min <u>er r</u>	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: Whi	te					
hours matur Exam			Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/Industry						
36 iin 72 han "dical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		,							
-00 d with giene ther t	Completed	0 17. Father's Name (First, Middle, Last)	None 18.Mother's Nam	e (First, Middle, M	None aiden Surname)						
1215-0036 Id be filed within 72 hot dental Hygiene. narked other than "nat	Be (Derrick Clark, Sr.	Deborah	,	,						
Dre, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiens If litem 27 is marked other than "natural", or items 23a or 28a-fshe her traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)					
MD nd 2 sho alth and m 27 is			962 Telegraph Rd.;	Severn,							
ore, se lar se la la la la la la la la la la la la la			f Disposition (Name of cemetery, ory or other place)	Date uary 15,	20c. Location - City or	Town, State					
imC Page ment tant: or ot			s-Bethel Cem.	2008	Odenton, M	aryland					
3alt ermit. Depart mpor njury	The state of the s										
Physician	_	23a. Part I. Enter the disease, or complice to is that caused the death. Do no	1421 Crain Hwy. SE;	Glen B	urnie, MD	21061 Approximate Interval					
/Medical		failure. List only one cause on each lin.	t anto the mode of dying, abon de dardide	or respiratory arres	or, orroom, or mount	Between Onset and Death					
aminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				Dodn					
		Sequentially list conditions, b.									
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
	хаш	events resulting in death) Last Due to (or as a consequence of):									
ecuted and transit		d									
a a e	Medical	UNPENDED AMENDED									
8760, tificate be ng physic as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancv	23d. Date of delivery Month	eay Year					
Box 68's death certificate attending	icia	past 12 months? 4 Pregnant at time of death		,		,					
. Bc he dea / the a hed fo	Physician	3 Olikilowii		Loo Division	1						
Division of Vital Records, P.O. Box 68: Hospital or Attending Physician: The law requires that the death certificate hours after death. The law requires that the death certificate has been signed by the attending rely filled in by the funeral director, page 2 should be detached for use as 1	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to 2 ✓ No 3 Prob						
Vital Records, hysician: The law require this certificate has been si director, page 2 should b	Completed			24a. Was a		topsy findings available					
ecol he law te has ige 2 sh	autopsy prior to completion of cau performed? 1 ✓ Yes 2 No 1 ✓ Yes 2										
tal Rectian: The certificate ector, page	1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)										
Vita hysicia this ce	TO B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	utpatient 3 DOA Other Nursi	ng Home 5 F	Residence 6 Other	:					
n of ing Ph After i uneral		(Month Day Year)	Time of Injury 28c. Injury at Work?		ow injury occurred truck by auto						
SiOr offeath death ctor: y the	äţi	2 Accident Investigation	Tes 2 W No								
Division tal or Attendia is after death.	2										
Divospital ospital of hours all uneral I	4 Homicide determined (Specify) Major Road / Highway 7962 Telegraph Road, Severn, MD 29a. Certifier (Check only) 1 Certifying Physician: 70 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: completely filled in by the fu	e(s) and manner as state and place, and due to the										
To Wift	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor						
1		1///	O.C.M.E.		January 11, 2008						
OCM		30. Name and address of person who completed cause of death (Item 23a)									
		Mary G. Ripple MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, I	MD 21201							
St Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature	matt 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Usha Gyani Chaudhry January 13, 2008 10:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9344 Copenhaver Drive Potomac Maryland 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Min 1 □ M 2 🕅 F 63 217-64-4135 1944 India Director May 6, Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐Yes 2 No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or dical Examiner must be r United States 9344 Copenhaver Drive 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1979–1986 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Asian Indian þ 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.

?? is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 5+ Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keshav Dev Gyani K. Kumari ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9344 Copenhaver Drive, Potomac, Maryland 20854 Dev R. Chaudhry / Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 15 January 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc. 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue M01473 Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final sease or condition **Physician** Glioblastoma Multiforme 22 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2█ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown signed by the period of the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🛛 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Tyes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physician: ours after death.
neral Director: A
filled in by the fu ō

with the Maryland

death

and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Certification: To

Medical

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

within 24 hours a

To the Funeral I the Hospital

State Registrar

and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43083 January 14, 2008

M

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

George A. Sotos, MD 9707 Medical Center Drive, #300, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JAÑÜÄRY 13 MILTON 2008 COHEN 3:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09/27/1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 218-12-0993 1 X M 2 ☐ F 83 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 8 LONGSTREAM COURT, #101 USA 21209 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER CONTRACTING SALE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOSEPH** COHEN JENNY SINGER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEA COHEN / WIFE 8 LONGSTREAM CT., UNIT #101 BALTIMORE, MD 21209 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ARCANETA CENTERON OF THE COLOR 1 Neurial 2 Cremation 3 Removal from State 01/15/2008 BALTIMORE, MD 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications / Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau. . . . each line. Immediate Cause (Final disease or condition END STATE RENAL DISEASE
Due to (or as a consequence of): YEARS disease or condition resulting in death) DIABETES Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? (es 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 2**X** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XXIII aturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box Ö Vital Physiclan: 9 or Attending

for filled in by the funeral after death Hospital within 24 hours a

Funeral

Director

r 28a-f show notified at

l or ns 23a c must b

"natural", or items

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.

Health and Mental

tem 27

permit. Pages Department of I Important: If its any injury or o

Physician

/Medical Examiner

Maryland 21215-0036

Baltimore,

31. Date filed (Month, Day, Year) JAN 1 6 2008

29b. Signature and title of certifie

DANIEUE DOBERMAN, MD 32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6565 N CHARLES ST, SUITE 209 BALTIMORE, MD 21204

State

Registrar

29c. License number

D64395

29d. Date signed (Month, Day, Year)

JANUARY 13, 2008

08-00340 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Quinn Martin Dowlin State of Maryland / Department of Health and Mental Hygiene 2008 00709 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Ouinn Martin Dowlin Month Day January 12, 2008 1534 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 713 Fuselage Ave **Baltimore County** 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director oreign Maryland 217-29-1621 Months Days Hours 17 07/17/1990 XX M 2 Country) Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits Maryland Baltimore Essex Yes 2 X No notified at once, Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Judywood 21221 Lane U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 1 X Never Married 2 Armed Forces Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Widowed If Yes. Give Year 4 Divorced Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical more, MD 21215-0036
Pages 1 and 2 should be filed within 7.
rent of Health and Mental Hygiene. is marked other than Student Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ouinn Martin Dowlin, Sr. Be Donna Renee Petre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Renee Petre - Mother 104 Judywood Lane, Essex, Maryland 21221 If item 27 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Important: Bayview Crematory Inc 01/17/2008 Baltimore, Maryland Donation 5 Other Specify: 2/ Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. C1407 Old Eastern Avenue, Essex, Maryland 21221 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death Methadone and alprazolam intoxication with cocaine use Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last nd Physician/Medical X UNPENDED #MENDED. #25a,PII,27,28a-f, perME,g875, 1/30/08 TT Box 68760. phys the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown / the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b ģ Cardiomegaly Completed Records, has been s 24a. Was an autopsy performed? death? page certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical of Vital 26.Place of Death (Check only one) Be examiner? Hospital: Other; this Inpatient 2 ER/Outpatient 3 DOA 1 V Yes Nursing Home 5 Residence 6 🗸 Other: Scene After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Pending Yes 2 X No Fnd 1/12/2008 Fnd 3:31 pm unk 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be Division death. Director: To the

Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 713 Fuselage Ave. Baltimore, MD determined (Specify) Found: private dwelling Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie m.

29d. Date signed (Month, Day, Year) 29c. License number

January 13, 2008

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

Ling Li, MD 31. Date filed (Month, Day, Year) State Registra

32. Re strar's Signature

cal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 AWSO 05 ep 1-Bura 5 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner latiques Baldimone Emos 8. Date of Birth (Month, Day, Year) Jan 5, 1940 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 ₹M 2 □ F 216-60-9950 Director 68 Usual Residence of Decedent the Maryland unk 10d. Inside City Limits 10a. State unk 10b. County 10c, City, Town or Location ns 23a or 28a-f show must be notified at unk unk₁ □Yes 2□No Director 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? death with USA ural", or items 23a Examiner must b Funeral 14. Race - American Indian, unk 12. Was Decedent Ever in U.S. Armed Forces? un Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 ☐ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify. Specify: <u>Ş</u> 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bons Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4□Donation 5\Other(Specify) in state Funeral Sovice State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** BUSHINA E Xac EnBation /Medical Due to (or as a consequence of): Examiner Conce Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examine that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. led by the a detached f 9☐Unknown 9 Unknown n signed by tl Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 ate has been signated based based 1 1 Yes 2□ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1∐ Yes 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 1 N 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Manne Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) New Birth mo 2000

and manner stated.

Galtimons

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

(Check only

08-00338		Please Type or Print in Black Indelible Ink. Ensure All Copies	Are Legi	ble.					
Jarrett A. Dixon		State of Maryland / Department of Health and Mental Hyg -For State Certificate of Death		200	3 0071				
Physicia	لينا	Registrar	Reg. Date of Death		3. Time of Death				
Medical Exami			Month Danuary 12,	2008 Year	1247 hrs				
~		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	4				
`		North West Hospital Center Randallstown	O Data of Disth	Baltimore Cour	·				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Date of Birting	Foreign Coul	1.4				
Director	-	214-68-4654 1 M 2 F 3 6 Yrs. Usual Residence of Decedent	01100	0/ /7 // 300	P(I)				
any	ŀ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
≥	5	MD Baltimore Owings Mills			1 Yes 2 No				
Maryla 28a-f	Director	10e. Street and Number	10g	. Citizen of What Count	ry?				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men to fleath and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoot or other traumatic event, the Medical Examiner must be notified at once.		4830 Wainwright Circle 2117	oifu Ves or No-	14. Race - Americ	an Indian Black				
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 1 Yes 2 No		White, etc.					
her de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: An	nerican				
ours a atura xamir	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retired		6b. Kind of Business/In	- 1.				
16 n 72 h nan "u	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mark Le Yugara Free Operator	-/	Battimor	1 1.7				
15-0036 filed within 7 I Hygiene. ed other than t, the Medirs	E O	17. Father's Name (First, Middle, Last) 18. Mother's Name (I	First, Middle, Ma	iden Surname)	repartment				
215 be filed tral Hy ked of	Bec	Alexander Divon Doloi	res .	Sprigg	5				
MD 21215-C 2 should be filed v h and Mental Hygi 27 is marked oth	2	19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Ru	iral Route Numb	er, City or Town, State,	Zip Code)				
e, MD and 2 sho lealth and ttem 27 is		Dolores Dixon Mother & Hobert Ct. Ko 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Date	Stown, W	D 21133				
Baltimore, ME bernit. Pages 1 and 2 si Department of Health an Important: If item 27		1 Burial 2 Cremation 3 Removal from State crematory or other place)	0/00	Baltimor					
timor t. Pages rtment of rtant: If		4 Donation 5 Other Specify: Druid Kidge 1/8 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Val	1100		queral Si				
Balt permit Depart Impor		1 mile of rule as service literisee	12 Ra	1 . 0	W. W.D.21133				
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or i	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and				
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Occlusive Bilateral Pulmonary Thromboemboli			Death				
A		or condition resulting in death) Due to (or as a consequence of):							
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	cause. Enter Underlying Cause (Disease or injury that initiated								
nd uted	Ě	events resulting in death) Last Due to (or as a consequence or). d							
e exec cian ar rial - t	dical	UNPENDED AMENDED							
760 ficate b	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	101	23d. Date of delivery	ay Year				
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Box e death the att	hysi	1 Yes 2 No 9 Unknown g Unknown							
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Rec The ficate	Con	25. Was case referred to medical 26. Place of Death (Check or	1 Y Yes 2	No 1 Ye	s 2 No				
ital sician: s certi	Be	examiner? Hospital: A FROutpotion 3 DOA Other, Nursing		Residence 6 Other					
of V g Phy: fier thi	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2		ow injury occurred					
Sion (Mitendin death.	ition	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No							
Division of Vital Records, P.O. tall or attending Physician: The law requires that that the death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru ate)	ral Route Number, City				
Dispital nours a neral if filled									
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of the companies of the co	due to the cause the time, date a	cause(s) and manner as stated. date and place, and due to the cause(s)					
To t To t com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor					
	O.C.M.E. January 13, 2008								
20		30 Name and address of person who completed cause of death (Item 23a)		<u> </u>					
'50		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120)1						
Si Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
DHMH 17 Rev 1/2		ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ruth Eileen Dottavio /Medical 2008 22:24 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air, Maryland
Under 1 Year | If Under 24 Hrs. | 8. Upper Chesapeake Medical Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 👿 F Director 301-20-1553 83 08/30/1924 Ohio Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Fallston MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 must be 23a U.S.A.

14. Race - American Indian, Funeral 5 Upland Road 21047 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 10, 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent Real Estate Industry alth and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Donald Crawford Mae Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other tr Paul_R. Dottavio (husband) 5 Upland Road - Fallston, Maryland 21047 Baltimore, Pages 1 8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 X Other (Specify) Entombrent Bel Air Memorial Gdns: 01/12/2008 | Bel Air, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. as 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** ACUTE /Medical Due to (or as a consequence of): Examiner EMPHYSEMA END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed CHRONIC OBSTRUCTIVE PULMONARY physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sur Novaliono DOP096 MNUARY 19,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULFORD AVE BOLAIR, MD 21014 ANDREW WONTKOWSKI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 16

2224

32 Registrar's Signature

Funeral Director 28a-f show at

Baltimore, Maryland 21215-0036 Completed Be DINGLE ဥ **Physician** /Medical Examiner Examiner certificate be executed and Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as Por Š Completed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by Be မ completely filled in by the funeral Certification: Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 4a per dr., g875, 01/16/08dhb Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death O 7 **Physician** PEARL 9.30 AM DINGLE 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death
Baltimore 4c. County of Death Examiner Good Samaritan Hospital Baltimore City 7. Age (In yrs. last birthday) 90 Yrs. If Under 24 Hrs. 5. Social Security Number 6 Sex If Under 1 Year Birthplace (State or Foreign Country) Vear 1 M 2 F 213-05-6083 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Many Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified as ¥IXIYes 2□No Director Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4112 White Avenue by Funeral 21206 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2√√No If Yes, Give Year or Dates: White 1 ☐ Yes 201X No Specify: Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 yrs. N/A <u>Hecht Co.</u> Bureau of Adjustments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winfield Scott Hellman Lilly Day Boblitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Horner (Daughter) 7717 Babikow Rd. Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Belair Memorial M.G. 1-11-08 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home Jasselm 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPSIS disease or condition resulting in death) Due to (or as a consequence of): PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) BOWEL PERFORATION Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sabaeva MD RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FIEND CARAFVA: GSH LOCH RAVEN BLVD, BALTIMORE, MD, 21239

Registrar

State

31. Date filed (Month, Day, Year)

JAN 16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Day **Physician** Elizabeth J. DeForest 2008 Jan 8::00a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 405 - 38-5500 1 □ M 2 🔀 F Yrs. Director 76 21,1931 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MDBaltimore 1 ☐ Yes 2 No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Stemmers Run Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Switchboard Operator Commerical Credit 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Lorene Flora Ann Shawler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ordak/ friend 808 220th Street Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐Cremation 3 ☐Removal from State Baltimore National 1/14/08 Baltimore MD 5 ☐ Other (Specify) h uneral Service Liberisee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMPHUSEM A
Due to (or as a consequence of): **Physician** YEARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∐ Yes 2 200 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

સુ છ Elizabeth Records, Deforest Vital O Division 1008

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2 should be fill and Mental His marked ott

permit. Pages 1 and 2 should be Department of Health and Menta. Important: If them 27 is marked of any injury or other traumatic ew

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Hospital or Attending within 24 hours after death To the Funeral Director: completely

State

DANIEUE DOBERMAN, MD 31. Date filed (Month, Day, Year)

and manner stated.

29c. License number D64395

29d. Date signed (Month, Day, Year) JANUARY 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NORTH CHARLES STREET, SUITE 209

BALTIMORE, MD 21204

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU8 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 13, 2008 TONY ANTHONY DITHOMAS 10:44A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 205 Bear Ridge Road, Dunda1k Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 217-52-7488 56 03/05/1951 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Bear Ridge Road, #104 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Dithomas Rose Alessantrini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Mayo / Son 205 Bear Ridge Road, #104, Dundalk, MD 21222 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01/14/08 Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

10a. State

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit within 24 hours after death.

To the Funeral Director: Α
completely filled in by the for

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

After t

- 1	disease or condition resulting in death)							
		Due to (or as a consequence of):						
5	Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events	b. Cue to (or as a consequence of):						
IICAI EXAI	that initiated events resulting in death) Last	CDue to (or as a consequence of):						
completed by Filysicial/medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	delivery Day Year					
במ וא ב	Part II. Other significant conditions	contributing to death but not resulting in the underly	to the cause of death? Probably 4 □Unknown					
and in the				autopsy prior t	autopsy findings available to completion of cause of ? es 2 \(\square\$\) No			
	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)				
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 KResidence 6 □Other (Si	pecify)			
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
	3☐ Suicide 6☐ Could not be determined		actory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,			
	29a. Certifying Pr (Check only one) Medical Exam	nysician: To the best of my knowledge, death occuminer/On the basis of examination and/or investig	urred at the time, date and place ation, in my opinion, death occu	, and due to the cause(s) and manner irred at the time, date and place, and d	as stated. due to the cause(s)			
	29b. Signature and title of certifier	1//c	29c. License number	29d. Date signed (Mo	Janusco 14. 7.008			
- 1-	30 Name and Address of Boren who	corrected cause of death (Item 23a) (Tune Print)			. /			

DHMH 17 Rev 1/2001

State Registrar Martin

31. Date filed (Month, Day, Year)

225

32 Registrar's Signature

reene Street Baltimore, MD 21201

			1 - For State Registrar	State	of Maryland		artment of H			giene 20	08	00	716
	Decedent's Name (First, Middle, Last)						2. Date			ate of Death		3. Time of	Death
		Physician							Month January	Day 2008		10:54	лм М
j	/Medic Examin		4a. Facility Name (If not institution		umber)	4b. City, Town, or	Location of Deat		4c. County (10.54	All	
	LAGITII	161	8618 Lucerne	Road			Randal:			Baltin			
	Funeral		5. Social Security Number	6. Sex				If Under 24 Hrs			9. Birtho	lace (State or	r Foreian
	Director		212-46-5915	1 □ M 21∏ F	61	Yrs.	Months Days	Hours Min.	Oct 7,	Year)	Mary	try)	
	ס		Usual Residence of Decedent								<i>J</i>		
	ylan how		10a. State 10b. County		10c. City,	Town or Lo	cation				11	0d. Inside Cit	y Limits
	Ma B-f-	Director	MD Baltimore Randallstown									2√ No	
	7 28 2 28	ire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
	23a c	Funeral	8618 Lucerne R	211	33		US	A					
	within 72 hours after death with the Maryland ene. Than "naturel" or iteme 23a or 28e-f ehow he Modical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. Anned Forces?				Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					an Indian,	
٥	or its		1 Never Married 2 Married 1 Yes 2		2X No	2 X No			to rican, etc.)		Black, White, etc.		
3-003p	ours	d by	3 Widowed 4 □ Divorced	Widowed 4 Divorced Year or Dates:			1 ☐ Yes 2X No Specify:				Specify: black		
ก	72 h	Completed		t's Education st grade completed			dent's Usual Occupa kind of work done d		unk	16b. Kind of Bu	siness/Inc	dustry	
7	ithin a f	ηbj	Elementary/Secondary (0-12)	life			DO NOT use retired)						
V	ygier ygier t,	S	12					clerical					
	be fil tal H d ott	Be	17. Father's Name (First, Middle,						me (First, Middle,		9)		
<u>X</u>	Men Men arke	ဥ	Herman Charle	es Wright				Beatri	ce McClu	re			
Mar	and and iem		19a. Informant's Name/Relations				g Address (Street a						
2	and ealth m 27		Lisa Smith/ni	Lece			Lucerne	koad kai	ndalistow	n, MD	2113	<u> </u>	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel; or iteme 23a or 28e-1 show sny injury or other treumatic event, the Modical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	COTT	ce of Dispo netery, cren	sition (Name of natory or other place)	Date	20c. Location - (City or To	wn, State	
Ē	Pages ment of I ant: If Its ury or o		4 Donation 5 Other (S										
	permit. Depart Import eny inj		21. Signature of Euneral Service Ronald	Vicensee Wade	rector	S ²²	Name and Address	of Facility ar	d 655 W.	Baltimo	re S	treet	
0	40 E 2 9		Samo	11/14	Will-		ltimore,	•					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death.	Do not ent	er the mode of dying	, such as cardia	or respiratory arr	est,		Approximate Interval Betw	veen
F	hysician	Examiner	Immediate Cause (Final disease or condition		mal	F	achina	9 6				Onset and D	
	/Medical		resulting in death) Due to (or as a consequence of):										
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	n =		Sequentially list conditions, if any, leading to immediate cause. Enter Underfying cause. Enter Underfying										
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) 0 / 0	cate be executed physicien and the burial-transit	dicai	1 Minthoode of										
		Med	IF FEMALE:	1						- IV - W - CO	554		
5	th ce tendi	Physician/Me	23b. Was decedent pregnant	23c. If yes, ou	ic. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date of delivery			
	o dea	SIC	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of deat		Other (specify)			Mon	th	Day Y	'ear
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ń	ires that the death certifications signed by the attending dipe detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacco use contribute to the cause of death?			
3	en si		- Larloss to torive						1 🗆 Ye	1 Yes 2 No 3 Probably 4 Unknown			
ָ נ	ang rnysteien: The law fequir h. After this certificate has been s' funeral director, page 2 should	Completed	05teop	020515	\$				24a. Was a	n 24b. W	ere autop	osy findings a	vailable
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9	tor, p	0	25. Was case referred to medical	3 400.		<u> </u>	11/2000	26 Place of Dea	1 ☐ Yes		1105	2 NO	
•	ysic is ce direc	0	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2 ER	VOutpatien	3 □ DOA Other		. /		r (Specify	()	
2 6	g ru ier th	ı.	27. Manner of D ath	28a. Date (Mor	28c. Injury	28c. Injury at 28d. Pescribe how injury occurred							
To the Hoepital or Attending Physicien: The law requires that the death certificate to the Funestal Director: Affect this certificate has been signed by the attending from the funestal Director: Affect this certificate has been signed by the attending from the funestal function of the funestal directors.	ath. Fr: Afr	랿	1 Matural 5 Pendin 2 Accident investig		in, Day 16ar)	Injury	Work' M 1 □ Y	es 2 No					
2	or de	€	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Flace	of Injury - At home	e, farm, stre	eet, factory, office		28f. Location (St	reet and Numbe	r or Rural	Route Numb	oer,
5	s efter	Certification:	4 Hornicide	Build	ling, etc." (Specify)				City or Towr	, State)			
9	voire noepter or Attent within 24 hours effect deatl To the Funeral Director: completely filled in by the		29a. Certifier / Curtifyin	g Physician: To the	e best of my knowle	dge, death	vecumed at the time	s, date and place	, and dua to the ea	tuse(s) and n an	ner as sta	ated.	
1	n 24 he Fi	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
-	Tot	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
			1172 Phrodusa 114/08										
			30. Name and address of person	who completed caus	se of death (Item 23	3a) (Type, I	Print)	0	n	11	11		
			4000013	(00st	05/7	00	, Just	500	11,16	11/6	171	ucylo	760)
	Stat		31. Date filed (Month, Day, Year)		Registrar's Signature	θ /					· · · · ·		_3
	Registra	ar	JAN 16	2008	was St.	1934	a					3/	1508

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12 **Physician** 3:00 PM 2008 Grace Farish Marv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 47'th Street Harbor View Park Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M Director 67 April 4 1940 Maryland <u>213-36-3196</u> Usual Residence of Decedent the Maryland la or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland | Baltimore Harbor View Park 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Heatilth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any inury or other traumatic event, the Medical Examiner must be no 47'th Street 584 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ð Specify: 3 ☐ Wildowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NA Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saunders Emma Sutton Howard ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deborah Ann Welch (Daughter</u> 584 47'th Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State January 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory Inc. 21. Signature of Funeral Septice Light see 22. Name and Address of Fagility
W. Dabrowski/Chojnacki Funeral Homes P.A. ash 1005 Dundalk Ave. Baltimore, Maryland 21224 23. Part. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a insequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unchying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 ☐ Yes 1□ Yes 2☐No 2∏ No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NR Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

within 2

State Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

2008

to

completed cause of death (Item 23a) (Type

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Marylar		artment rtificate			ınd M	lental Hy	/gien Reg. N	00	nο	00710
į,	Physici		Decedent's Name (First, Middle,	Henry W.	L. Fr						2. Date of D Month Januar	eath	L . U	Year	3. Time of Death 10:20 P M
	/Medio Examir		4a. Facility Name (If not institution, Shady Grove Adv	give street and num	ber)		4b. City, To		Location o		Sanda	4	c. County	of Death	<u> </u>
-	Funeral		5. Social Security Number		7. Age (In yrs.		If Under 1		If Under 2 Hours		8. Date of B (Month, D Oct. 1		Monte	9. Birtho	y ace (State or Foreign try) yland
ŀ	Director		216-12-9771 Usual Residence of Decedent 10a. State 10b. County		84	y, Town or Lo	og ation				Oct. I	2, 1	923		
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USP	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examilner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford d 1 Tes If Yes, Give Year or Da	ces? 2 ሺ No		Was Decede If Yes, specif 1 ☐ Yes 2[spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-		e - Americ k, White, Wh	
3500-6171	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	done di retired)	uring most				Kind of Bu		lustry
lana z	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, La Henry Fricke	ast)		1			18. Mother	r's Name	(First, Middle a Weber	e, Maide		-	
Mary	d 2 sholth and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relationship				ng Address (S						-		,
nore, I	ages 1 and out of Healt if item 2 y or other		Dorothy L. Fric 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 [XOther (Spe	B □Removal from S	tate p	ZIZO Place of Dispo cemetery, cre rklawr	7 Emera psition (Name matory or oth Memor	of	1	Janua	ary 16,	20c. l	_ocation -	City or To	wn, State
Daltimore	permit. P Departme Importan any injur		21. Signature of Funeral Service Li	• •	110	Pa	ırk			20 rey	08 Funera	1 He	ckvil ome/R	le, Rockv	<u>Maryland</u> ille, Inc. 2085 0- 2805
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate.	a. Arr Due to (o	used the deat	n. Do not end a uence of): re Hear	ter the mode	of dying	j, such as (VILIC	, 110	Approximate Interval Between Onset and Death
,0070	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pne	eumonia rasaconseq :hma										
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending picture the Funeral Director. After this certificate has been signed by the attending picture in by the funeral director, page 2 should be detached for use as it.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2□Feta intattime of d	I death 3	⊒Ectopic preg □ Other (spec						23d. Date Mor	e of delive	ry Day Year
Olds, T	quires that n signed b uld be deta		Part II. Other significant condition Hypertension	s contributing to dea	ith but not res	ulting in the u	nderlying cau	se give	n in Part I.						e cause of death? ably 4 🙀 Unknown
משבו וג	: The law recate has bee	Completed by	<u>Diabetes Melli</u> Diabetes Melli		Insuli	n Depe	ndent				24a. Was auto peri 1 Yes	an opsy ormed? 2 N	p	rior to cor leath?	osy findings available npletion of cause of 2 No
<u> </u>	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2	ER/Outpatier	nt 3□ DOA	Other	r·		<i>(Check only</i> ne 5⊟Res		6 □Otho	or (Specifi	·)
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2	ital or Att irs after de ral Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 28e. Place c	of injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory, o	office		2	28f. Location City or To	(Street a	and Numbe te)	er or Rura	Route Number,
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	(Check only 2 Medical Ex	Physician: To the base caminer: On the base and manne	sis of examina	wledge, deat tion and/or in	vestigation, ir	my op	inion, deat	d place, a	and due to the	, date a	nd place, a	and due to	the cause(s)
	To con	2	29b. Signature and title of certifier	Kapia	M	D	M	D				JA	ate signed	HRY	13, 2008
2	0		30. Name and address of person will 604 S. FRE.	DERICK	- A1	VE, S	SUIT	tan	Kasi	de M	1.D. HTHE	RS B	URG	, 1	1D 2087
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			State of Maryland /			ental Hygi	ene 2008	00719
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of I	Death		g. No. 2 0 0 0	00713
	Physici	ian	Christine Georgia Fores	tor		2. Date of Death Month	Dav Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)		r Location of Death	January	11, 2008 4c. County of Death	6:15 PM
A. Rei	Examir	ner	Montgomery General Hospital		ney		Montgon	
45	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		417–30–0730 ^{1□ M 2} ♥F 83	Yrs. Months Days	Hours Min.	May 4, 1	rear) Cou	intry) Dama
	pu		Usual Residence of Decedent					
	anyla show d at	<u>-</u>	10a. State 10b. County 10c. City, Tow	wn or Location				10d. Inside City Limits
	he M 28a-f otifie	Directo	Maryland Montgomery	Laytonsvill	le			1 □Yes 2 X No
	with the Maryland a or 28a-f show the notified at	ä	10e. Street and Number	10f. Zip Code			g. Citizen of What Cou	,
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	r iten	들	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto F	Rican, etc.)	Black, White	
15-0036	within 72 hours after death with the Maryland tene. than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at	by	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	nite
ဂ္ဂ	72 hc natui lical	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	a. Decedent's Usual Occupa	ation	10	6b. Kind of Business/li	ndustry
N	ithin ne. nan "	햩	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	d)	9	_	
7	filed w Hygier Ather th	වී	10	Homemaker			Own Home	
yland	be find Head Head of the contract of the contr	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		,	
	should be ind Mental imarked o	ဂ္		h Mailing Address (Chrost		e J. Hut		
Mar	ges 1 and 2 should be filed within 72 hours after death w it of Health and Mental Hygen. If item 27 is marked other than "natural", or items 23a If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must			b. Mailing Address (Street at 1809 Woodfie)				
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saitimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral/Service Ligensee					•
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00	ifficate g phy as the	•	0	7 7 7 7 7		<u>C</u> = 1 / 0		
X O	h cert	Z V	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	ا ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱ ۱			23d. Date of deliv	very
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ń	res th	by	Part II. Other significant conditions contributing to death but not resulting in		en in Part I.		cco use contribute to	
cords,	requi	sted	STATE CONTRACTOR	> 2) XO	KC,	1 L Yes	2∐ No 3∐ Pro	babiy 4. Unknown
กั	e law has b je 2 s	Completed	HYDERTENSION.			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
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5	Physic this stal di	5	Tempatient 2 ER/OL	dipatient 3 DOA	4 LI Nursing Hom	e 5 Residend Bd. Describe how	ce 6 Other (Speci	ify)
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2	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, fa	arm, street, factory, office	28	3f. Location (Stre	_ et and Number or Rur	al Route Number,
5	tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death. Within 24 hours after death. Within 24 hours after death. On the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only (Check only a Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are	e, death occurred at the tim	ne, date and place, a	nd due to the cau	se(s) and manner as	stated.
	the hin 24	Medical	and manner stated.					
	So Mit		29b. Signature and title of certifier	4.0 DOS	57630		Date signed (Month,	
_	~	-	10,00		7/030		01-12-	2008
	`		30. Name and address of person who completed cause of death (Item 23a) Anuradha Arun, M.D. 10301 Georgia		e. 209. Si	lver Spi	ring. Marw	land 20902
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	_ III ondo	o, bi	TACT OD	,a. y	10110 20702
	Registra	A	IAN 1 6 2008	Marks.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] State Registrar Amend #1,perMD,g875, 1/16/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Aleace Gray JANU ARY /Medical 4a. Facility Name (If not institution, give street and nu 4c. County of Death 4b. City, Town, or Location of Death Examiner andallstoun Morthwest 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days MARYLAND 1 □ M 2 1 F 86 Director 220-18-5179 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits or 28s-f show if Item 27 is marked other than "naturel", or Items 23s or 28s-f shot or other traumatic event, the Modical Examinar must be notified at MD N/A BALTIMORE CITY Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 ARAGON AVENUE 21215 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: Specify: BLACK 3℃Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry BUREAU OF (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 8TH College (1-4or 5+) RECREATION & PARKS CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD RICH BERTHA JOHNSON ဂ permit. Pages 1 and 2 sho Depertment of Heelth and M. Importent: If Item 27 Is me-any Injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA G. ALLEYNE / DAUGHTER 4001 ARAGON AVENUE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CÉMETERY 01/21/08 BALTIMORE CO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD or heart fail at List only one cause on each line. g, such as cardiac or respiratory arrest,

Approximate Interval Between and Death

Approximate Interval Between and Death hier the mode of dying, such as cardiac or respiratory arrest, Immorate Cause (Final disease condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Mospitel or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by venlacement 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

No 24a. Was an myocardial infavction) performe /es 2 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 22 No Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ HOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) D0052760 JAMUARY 14,2008 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT POAD RAMPHISTORY 5 401 MULISHOW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MARYLAND Z1133 JAN 16 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WARY 12, Year JOS **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1906 Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours 101 159-01-7754 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Yes 2 No DC Washington D.C. 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2500 Wisconsin Avenue 20007 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meyer Gorrin Rebecca Finkel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10201 Grosvenor P1 #509; Rockville, MD 20852 Gloria B. Lubkin/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 1/15/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 933 Gist Ave. 20910 21. Signature of Funeral 22. Name and Address of Facility MO0382 Rapp Funeral & Cremation Svc.; Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 12 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) s after death.

**al Director: After this or that in by the funeral director. Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannel of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) JANUARY 12, 2003 29b. Signature and title of certifie 30. Name and address of person who WIRDERD, DUCK VILLE, MD 20852

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 6 2008

32. Fedistra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 18 19a per fh e877 3-13-08vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ADNR JAnsuno 2008 NON /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4¢. Qounty of Death **Examiner** (4) mandalls forms trucat UZTUWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/31/1955 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) curity Number **Funeral** Days 1**X** M 2□ F 219-66-5315 MARYLAND 52 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE GWYNN OAK Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 CHARLESWOOD COURT 21207 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
if Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify: Specify: BLACK 3 □ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED BARBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIAN YOUNG Mamie Lou Sanders JOHN GLADNEY ۵ 19a. Informaet's Name/Relationship (Type. Print)
LIBERAN GLADNEY MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 CHARLESWOOD COURT, GWYNN OAK, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 01/19/08 WINDSOR MILL, MD KING MEM. PARK CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 5 neral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Approximate Interval Between Onset and Death complications that caused the deat List only one cause on eac Line. o not enter the mode of dying, such as cardiac or respiratory arrest, the dise Immediate Cause (Final disease Indition resulting in death) **Physician** 020 MAD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least on the immunist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the hinder Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes ed by the detached 9☐Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Winknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Abstray 2 □ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) it Road Randallstone, MD 1/2 a 401 STEVEN 00

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month UAR Day 12, 2008 **Physician** 8:42AM Guages Gerara /Medical 4c. County of Death Haltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death **Examiner** Center 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X**M 2□ F 58 212.52.7051 01.01. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show notified at Baltimore Kandallstown 1 ☐ Yes 2 No MD Funeral Director 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 1814 USA 21133 Valley torge death 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after dea nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Exminer mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: BOCK Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nurse 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mulde Gunes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21132 19a. Informant's Name/Relationship 20b. Place of Disposition (Name of cemetery, crematory or other)
St. Alph DNSW (e 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemeter DI. 16-08 Woodstock, MD aughn C. Ercene Funeral Svcs 21. Signature of Funeral Service Licenses Randallstonin MD 21133 8728 Liberty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Onset and Death Immediate Cause (Final LUNG CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) 5 DAYS Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of DIABETES MELLITUS TYPE 2 24a. Was an s certificate has b autopsy death? 1 ☐ Yes ASBESTOS EXPOSURE performe 2**X** No 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

Registrar

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CHRISTINE

JAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOUTZALE

M.D.

32. Registrar's Signature

D58944

OSLER DRIVE, TOWSON,

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 008 Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) January 15, 2008 **Physician** Betty Bean 3:50am M Goslee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Transitions Health Care Sykesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 18, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours MD 578-32-5889 83 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or teme 23a or 28a-f ehow with injury or other traumatic event, It a Medical Examinal must be notified at once. 1 Yes 2 No MD Carrol1 Eldersburg Completed by Funeral Director 10f. Zip Code 10g. Citizen of Whal Country? 10e Street and Number 2028C Rudy Serra Drive 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Administrative Claims Rep. Social Security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leah Estelle Trotter John Milton Bean 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Janet Zepp Dixon (Daughter) 6405 Oak Hill Dr., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2\ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1/16/2008 Sykesville, MD HATCHT FUNERAL HOME & CHAPEL. PA (Box 195) Sykesville, MD 21784 21. Signalure of Funeral Service Licenses MODIE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. therosciennic Cardiovascular Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant al time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: AND Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1-Natural 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 4 | Homicide 🗫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Japiter ...
4 hours after dea...
- **rai Director: After to the function of th within 24 hours after To the Funeral Dire completely filled in by

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMUDD

19

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 14 Month Physician 2008 5:20 A M January Beverly Ann Grunder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2**X**F Months Days 64 214-44-6981 09-01-1943 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylis Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No MD Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2908 Inglewood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Tutor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Walker William Eivner မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 532 Stevenson Lane, Towson, MD 21286 Frank W. Grunder, III/Son 20b. Place of Disposition (Name of Him top Service) Hill top Service Corporation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1-19-2008 Towson, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Middle 1050 York Road, Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ivision or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2**9** No 2 ER/Outpatient 3 DOA 1 ☐ Yes မ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

3

Medical

29a. Certifier

30. Name a

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

agazet.

and manner stated.

32. Registrar's Signature.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician MARGARI 2008 JANYARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washinston VIKNIE If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** Days Min. Months 1 M 2 TF 82 Director 255 40 2516 Georgia 18 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 21225 U.S.A. 310 W. Arundel Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Baltimore, Maryland 2121 College (1-4or 5+) 2 should be filed withi and Mental Hygiene. Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Wyatt Alline Barron ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an 310 W. Arundel Road Baltimore, Maryland 21225 Ralph Gallman / Husband permit. Pages 1 as Department of Hea Important: if item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 01/17/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Y EARLS /Medical Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical attending IF FEMALE If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death ρ in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0.1 ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2 No After this certificate 1□ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2X ER/Outpatient 3 DOA ည funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: At completely filled in hours. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) son who impleted cause of death (Item 23a) (Type, Print) S. GRAIN ITWY - GLEN BURNIE 21650 1406 a. D

State

Registrar

31. Date filed (Month, Day, Year)

16

32. Régistrar's Signaturé

Villiam Milton H		1- For State	of Maryland /		rtment of <i>tificate of</i>		nd Mei	ntal Hy		eg. No. 🤌 (100 00	70
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,La	st)					12	2. Date of Deat		3. Time of Dea	tn /
Medical Exami		William M. Hea	rne Ir						January 8	2008	1210 hrs	
May May		4a. Facility Name (if not institution, gi 227 Broad Street	ve street and number)		4	b. City, Town, Berlin				4c. County of Worceste	er	
Funeral Director		5. Social Security Number 6. S 218–16–6247	Sex 7. Age	(In yrs. la	ist birthday) Yrs.	If Under 1 Y	ear If Uni		1		9. Birthplace (State o Foreign Country)Mary	
		Usual Residence of Decedent	A	0.3	110.				Nov 2	, 1924		
w any		10a. State 10b. County		10c. City,	Town or Location						10d. Inside Cit	
Maryland 28a-f show any <u>d at once.</u>	ğ	MD Worces	ster		Berli	n 10f, Zip Code				0g. Citizen of Wha	1 Yes 2	X_No
1 with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 227 Broad Street	t				21811		'	USA	at Country?	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Manital Status 1 Never Married 2 Mamie	12. Was Decedent I Armed Forces?			Decedent of s, specify Cul			cify Yes or No Rican, etc.)	- 14. Race - White,	- American Indian, Blac , etc.	ck,
ifter de		3 XWidowed 4 Divorce	1 Yes 2 .d If Yes, Give Yeer or Dates:	X No	1	Yes 2 X	No specif	y:		Specify:	white	
hours a	Completed by	15. Decedent's Education (Specify of	only highest grade com	1.7	16a. Decedent	's Usual Occu				16b. Kind of Bus	siness/Industry	
36 in 72 l	plet	Elementary/Secondary (0-12)	College (1-4 or 5	+)	·				•	1.0		
d with	ĕ	11 17. Father's Name (First, Middle, Las	<u>O</u>		car	penter	18.Moth	er's Name (First, Middle, I	SEII & Maiden Surname)	employed	
21215-0036 build be filed within 72 hours after Mental Hygiene. marked other than "natural", ic event, the Medical Examiner.	Be B	William M. Hear							McGee			
nd J	٩	19a. Informant's Name/Relationship (, , ,		1						n, State, Zip Code)	1
y, MD 21215-003 and 2 should be filed withi teath and Mental Hygiene, tem 27 is marked other ti traumatic event, the Med		Lynn Ziesing/dar 20a. Method of Disposition	ugnter		Place of Disposi	tion (Name of			ine, MI Date		City or Town, State	
imore, MD 2 Pages I and 2 shou nent of Health and I iant: If item 27 is n or other traumatic		1 Burial 2 Cremation 3		"	rematory or oth	er place)						
Baltimore, MI purnit Pages I and 2.8 Department of Health a Important: If item 27 injury or other traum		4 X Donation 5 Other Specification of Funeral Service Lice Ronald Service Lice Ronald Service Lice Ronald Service Lice Ronald Service Ronald Ron	ensee Dire	ector	22. N	ame and Addr	ess of Faci	Hoard	655 W	. Baltimo	ore Street	
		23a. Part I. Enter the disease or com	Mile	CLOI	Bal	timore	MD	2120	1			later and
Physician ~∵ /Medical		failure. List only one cause on e	each line.			e mode or dyi	ng, such as	cardiac or	respiratory arr	est, snock, or nea	rt Approximate Between On Deat	set and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Intra-oral Gunsh Due to (or as a conse									
		Sequentially list conditions,	o									
	nine	if any, leading to immediate rause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	quence of	n):							
rted d ansit	Examiner	events resulting in death) Last	Due to (or as a conse	quence of	j):							
60, nte be executed hysician and e burial - transit	Aedical	UNPENDED	AMENDED									
876(tificate ng phy as the b	M/L	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregr		al death	3 Ecto	pic pregnan	псу	23d. Date of o Month		ear
Box 687 death certificathe attending point of for use as the	Physician/	1 Yes 2 No 9 Unknow	4 Pregnant at	time of dea	ath 5 Oth	ner (Specify)						
O. En at the d by the		Part II. Other significant conditions		but not re	esulting in the u	nderlying cau	se given in	Part I.	23e. Did t	obacco use contril	bute to the cause of de	eath?
S, P.O. Lires that the signed by d be detacled	ed by									s 2 🗸 No 3		nknown
of Vital Records, ng Physician: The law require nfer this certificate has been si meral director, page 2 should b	Completed								24a. Was	osy p	Vere autopsy findings a rior to completion of ca eath?	
Rec The l	E O								1 ✓ Yes		✓ Yes 2	No
ital sician: s certil irector	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatient		Other	h (Check o		Residence 6	Other: Scene	
of V ig Phy fter thi	٩	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Yo Jan 8, 2008		28b. Time of Ir		Injury at Wo	ork?	28d. Describe	how injury occurre		
ion ttendir leath tor: A	ation	1 Natural 5 Pending 2 Accident Investiga		sai)	1157 hrs	1	Yes 2	✓ No	Subject sho	ot seit		
Division tal or Attendii rs after death, al Director: A	Certification:	3 Suicide 6 Could no determin	ot be 28e. Place of Inj	-		t, factory, offic	e building,	etc.		Street and Numbe State) reet, Berlin, MD	er or Rural Route Num)	ber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial: transit		29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledg	ge, death occur	red at the time	, date and	place, and o	due to the cau	se(s) and manner	as stated.	
To the within To the comp	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my opinion, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dat										ed (Month, Day, Year)	_
	And his, mrs O.C.M.E. January 9, 2											
		30. Name and address of person who	o completed cause of de Medical Examiner			t, Baltimor	e, MD 2	1201		•		
S	ate	31 Date filed (Month, Day Year)	32 Registrar			ep .						
Regis		JAN 1 6 20	UO Salar	100	A CONTRACT							

00728 State of Maryland / Department of Health and Mental Hygien 2 0 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** January 1, 2008 10:15 AMM Mary B. Harry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill Rock Spring Village If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Hours 1 ☐ M 2 🛱 F Yrs 96 Dec 17, 1911 Virginia Director 214-24-5464 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21050 2005 High Point Road Iteme 23a Pages 1 and 2 should be filed within 72 hours after deeth inent of Health and Mental Hygiene. Int: If item 27 Ie marked other than "netural", or Iteme 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) medical technician healthcare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alfred Walter Biddlecomb Almeda Frances Robinson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 High Point Road Forest Hill, MD 21050 Nathalie Smith/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If its eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee donald S. Wad State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Ment **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sunsequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit physicien and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cete has been signed by the cage 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by yser ponathy poides n 2500 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes certificete has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certifier 29c. License number 00050414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Lutriaville, mo 21093 Aucot Falls JOHN N 125 10755 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, 22 per fh 98/5 1-24-08 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day JUCS **Physician** 20:40 M ANUMARO Delores Holland /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAINT AGNES HOSPITAL ALTMORE If Under 1 Year | If Under 24 Hrs. | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 😾 F Director July 15, 1954 215-70-0630 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 1√⊈Yes 2 ☐ No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 701 Edmondson Avenue 21228 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o
once. 1 ☐ Burial 2 【Cremation 3 Removal from State Ardent Crematory Serv. 1-22-08 Hanover, Md. 4 Donation 5 X Other (Spec 22 Bever North of Romartie F/S 2700 Edmondson Ave State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21223 23a. Part1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C. u.v. (Final disease or contion resulting in death) Physician End Stage Liver inknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-trai Due to (or as a consequence of): HULAND, UEUMES Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 2 **V** No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗌 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie January H 62862 of person who completed cause of death (Item 23a) (Type, Print)

100 Caton AVE. Batti Baltimore, mD 21229 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:56 AM 2008 William J, Hill JANHARY 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL BALTIMORE SAINT AGNES If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Jul 29, 19 Maryland 219-52-8815 8 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No Baltimore City N MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Parksley ILSA 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smoth Alice Maynard Vene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21223 Porksley Are, Rosetta Hill 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Western Cemetery Jan 18,2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rinaly A. Ennyson Fune
270 Fred Hyten Bass. 21. Signature of Funeral Service Licensee agrapen mald 1304 t. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS WEEK Due to (or as a consequence of): METHICILLIN RESISTANT STAPHYLLOCLOCUS PNEUMPNIA WEEKS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician/Medical Examiner Completed by

Medical Certification: To Be

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be file frient of Health and Mental Hi lant; If Item 27 Is marked oth jury or other traumatic event

permit. Page Department o Important: If

Physician

/Medical

Examiner

the burial-tra

page 2

director

Vital Physician:

Division or

or Attending

after death

within 24 hours a

completely

Injury

Maryland 21215-0036

Saltimore,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

> 3 Suicide 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

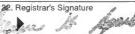
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAADU ISHAQ, SAINT AGNES HESPITAL, NO. 900 CATON AVENUE DR. JAIDU 31. Date filed (Month, Day, Year)

State Registrar



State of Maryland	/ Department of Health a
	Certificate of Death
	· · · · · · · · · · · · · · · · · · ·

	•	State Registrar			Ce	ertificate of L	Death	Reg. No. 2008 00731				
Physicia		1. Decedent's Name (First, Middle		_				2. Date of Dea Month	_	v Year	3. Time of Death	
/Medica	1		Margare	t Lo	ouise	Hawley		January		2008 2008	10:55 P M	
Examine	er	4a. Facility Name (If not institutio					Location of Death			. County of Death		
2		4821 Drummond		. ()	4 & !46	Chevy	Chase If Under 24 Hrs.	I n D-44 Bi-41		Montgome		
Funeral Director		5. Social Security Number 220-70-9500 Usual Residence of Decedent	6. Sex 7. Age 1	52	as <i>t birthda</i> y Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day October	r, Year)	Cou	place (State or Foreign ntry) higan	
land w	ŀ	10a. State 10b. County	/	10c. City	, Town or L	_ocation					10d. Inside City Limits	
Mary f sho	ĕ	Maryland Monte	gomery	,	'h ouu	Chase					1 XYes 2 □ No	
the	Director	10e. Street and Number	30mery		nevy	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Cit	tizen of What Cou	ntry?	
3a o	<u></u>	4821 Drummond A	Avenue				20815		Uni	ted Stat	es	
death	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp			14. Race - Ameri	can Indian,	
urs a	۾ ا	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 ☐ Yes 2 💢 N If Yes, Give	No		1 ☐ Yes 2 X No	Specify:	o nicari, etc.)		Black, White, Specify: Wh	ite	
72 ho	ted	15. Deceder	nt's Education est grade completed)		16a. Dec	edent's Usual Occupa	ation	king	16b. K	(ind of Business/In	dustry	
thin le.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	re kind of work done o DO NOT use retired	l)	Ning				
ed wi ygier ier th t, th	ပ္ပံ		5+		Fina	ncial Anal				rernment		
tal H	Be	17. Father's Name (First, Middle,	,				18. Mother's Nam			,		
Mer Marke Marke	ပ	Eugene Francis						sephine				
12 st h and 7 is n traun		19a. Informant's Name/Relations				ling Address (Street a					•	
1 and Health em 27 ther tr		Suresh Sankarar 20a. Method of Disposition	ı / Husband	20h. P!		Drummond		_		ocation - City or T		
Pages nent of h int: If ite		1 ☐ Burial 2 X Cremation		1		position (Name of rematory or other place	1	-				
it. Partme		4 □ Donation 5 □ Other (\$ 21. Signature of Funeral Service		rieci		an Cremator					Virginia	
permit. Departimonts any Inj		Muselette		1305	R	obert A. Pun 7557 Wisconsi	mphrey Fund in Avenue,	eral Home/ Bethesda,	Bet Mar	hesda-Chev yland 2081	y Chase, Inc. 4-3501	
A SEC		23a. Part1. ter the disease, o shock, r heart failure. Lis	or complications that caused at only one cause on each lir	the death ne.	. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition	_a Meta	stati	c Bre	east Cance	r				3 Years	
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	_	Sequentially list conditions,	b									
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence or).							
execu	xar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):							
d> (0) =												
ifficat g phy as the	Medical											
h cert		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregna	ncy	ПГ-+				23d. Date of deliv	/ery	
w requires that the death c been signed by the attend should be detached for us	Physician/	in the past 12 months? 1 □ Yes 2 🗓 No	1□Live birth 4□Pregnant at			□Ectopic pregnancy □ Other (specify)				Month	Day Year	
at the by th tache	hys	9 ☐ Unknown	9□Unknown									
es tha	by	Part II. Other significant condit	ions contributing to death be	ut not resu	lting in the	underlying cause give	en in Part I.				the cause of death?	
equir sen si ould I								1 D Y	es 2	2⊠No 3∏ Pro	bably 4 Unknown	
law r as be 2 sh	Completed							24a. Was a		24b. Were aut	opsy findings available ompletion of cause of	
The ate h	ĕ							perfo	rmed? 2⊠No	death? o 1 ☐ Yes	2 □ No	
clan: ertific	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o				
hysik this o	ျှ	1 X Yes 2 No	Hospital: 1 ☐ Inpatie			ent 3 DOA Othe	4 LI Nursing H	ome 5ሺ Resid	lence	6 □Other (Speci	ify)	
ing P		27. Manner of Death 1 X Natural 5 □ Pendi	28a. Date of Inju ing (Month, Day	ry y Year)	28b. Time Injury	Worl		28d. Describe h	now inju	ury occurred		
tend leath. tor: /	cati	2 Accident invest 3 Suicide 6 Could	I not be				Yes 2 □ No	0001 11 10				
or Atlanta	Certification:		mined 286. Place of inju- building, etc	ury - At no c. <i>(Specify</i>	me, tarm, s	street, factory, office		28f. Location (S City or Tow	street a vn, Stat	nd Number or Rur le)	al Route Number,	
spital ours neral filled		29a. Certifier 1 X Certifyi	ing Physician: To the best	of my knov	wledge, de	ath occurred at the tir	me, date and place	and due to the	cause(s	s) and manner as	stated.	
To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us.	Medical	(Check only 2 Medica one)	i Examiner: On the basis of and manner sta	f examinat	ion and/or	investigation, in my o	ppinion, death occu	irred at the time,	date ar	nd place, and due	to the cause(s)	
To To	2	29b. Signature and title of certific		1			icense number 29d. Date signed (Month) 29d. Date signed (Month) 29d. Date signed (Month)					
~	ļ		MIG				J27J		Jan	uary 14,	2006	
		30. Name and address of person					#100	0 01		3.5	1 1 00015	
Stat	,	Frederick P. S 31. Date filed (Month, Day, Year				onsin Aven	ue, #130	o, chevy	Ch	ase, Mar	yland 20815	
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 **Physician** 8:30A JAN. 11, CORA SYLVIA JOHNSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE RANDALLSTOWN 8525 WINANDS ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/15/1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 👿 F Yrs. 74 MARYLAND 220-36-3752 Director Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No RANDALLSTOWN MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 8525 WINANDS ROAD 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER PRIVATE FAMILY 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WYATT MADDEN ANNIE MILIGAN ဥ Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 RETINUE COURT, #204, BALTIMORE, MD 21207 CLARA NELL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o XXBurial 2 Cremation 3 Removal from State KING MEM. PARK CEM. 01/17/08 WINDSOR MILL, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Juneral Service Licenses 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 21207 Approximate Interval Between Onset and Death se, or complications that caused the death. List only one cause on each line. 23a. Pary Enter the disease shock, or eart failure. η Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia ause (Final whyonaly **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9∏Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an HYPERLIPEDIMI autopsy performed? page 2 ANEMIA certificate 1∐ Yes 2X No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home State Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28c. Injury at Work? After (Month, Day Year) Hospital or Attending 1 Matural 5 Pending investigation a er death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 ☐ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig D40867 MD 30. Name and address of person who completed cause of downth (Item 23a) (Type, Print) SADOVNIK 1838 MIGUEL GREEN TREE Rd, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Maryla	•	irtment of H <i>tificate of L</i>			ene g. No. 2 A A S	00733
Į.	Dharaist		1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Dav Year	3. Time of Death
÷ 1	Physicia /Medic	_	KATHERINE		KINS	41. O'h. T	Location of Death	TANUAR	4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, give				IMORE	-	N/A	
	Funeral Director		5. Social Security Number 6. Se		rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 5.	Year) 9. Birt	thplace (State or Foreign ountry) ryland
24	tille sam skalper		Usual Residence of Decedent					- July 5,	1710 1141	10d. Inside City Limits
	eath with the Marylanns 23a or 28a-f show must be notified at	tor	Maryland 10b. County Anne A	Arundel 100.	City, Town or Loc Baltimon					1 ☐ Yes 2 ☑ No
	or 282	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a nust t		308 - 14th Aven	ue 12. Was Decedent Ever in	n II S 13 V	Vas Decedent of H		ecify Yes or No-	U.S.A.	erican Indian,
386	filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	te, etc.
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מם	be filed Ital Hygi Ital other event, tl	3e C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	flaiden Surname)	
Maryland 21	should b ind Ment inarked umatic e	일		am Jenkins	10h Mailin	an Address (Street		Ann Finn	City or Town, State,	Zin Cade)
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic	1	19a. Informant's Name/Relationship (7) Helen DiStefano		I	Woodview				ryland 21043
ore,	of Hea		20a. Method of Disposition	20	b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	ce)		20c. Location - City or	
Baltimore,	Pages ment of lant: If its		1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specify</i>) No	ew Cathe	dral Ceme	etery $1/1$	4/2008 B	altimore,	Maryland
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į,	8 4 7	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	,	OTTO	× 155	206		2 DAYS
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68760,	te be e ysiciar ne buri	edical E	(d						
	eath certificate be executed attending physician and for use as the burial-transi	/Med	IF FEMALE:	23c. If yes, outcome pf pre	egnancy				22d Date of de	Nivon
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transitions.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [⊒Ectopic pregnancy ☑ Other (specify)	y		23d. Date of de Month	Day Year
	uires that the de signed by the a d be detached t	by	Part II. Other significant conditions of	-	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	oacco use contribute t es 2 □ No 3 □ P	to the cause of death?
COL	aw require s been sig should b	olete						24a. Was a		utopsy findings available
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Viita	ysician; The iis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		oth	or:	th (Check only on		
ō	g Phys er this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	IL SELDOA	4 □ Nursing ⊓		ence 6 Other (Spe ow injury occurred	эcity)
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Division or	affor Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, str necify)	reet, factory, office		28f. Location (Si City or Town	treet and Number or Fi n, State)	lural Route Number,
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p.	edical C		ysician: To the best of my niner: On the basis of exar and manner stated.						
	To the within To the compl	Me	29b. Signature and title of pertifier			29c. Licens	se number	2	9d. Date signed (Mor	ith, Day, Year)
	,	33	<u> </u>	m.D.			E8001	J	ANUARY	10 9008
	5		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) UER STR	LEET B	ALTIMO	RE, MD ?	11225
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	- '	Will I				
	Regist	ar	JAN 16 40							

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of F		10.44	ene2008	00734
	Dhysisi		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Bertha Louise					Jan. 1	4, 2008	12:20P ^M
	Examin	er	4a. Facility Name (If not institution, give		1		or Location of Dear	th	4c. County of Deat	
	_		Brightview At 5. Social Security Number 6. S		S h s. last birthday)	Baltim If Under 1 Year		8. Date of Birth	Baltimo	holace (State or Foreign
	Funeral Director			□M 2ØF 92	Yrs.	Months Days	Hours Min		1915 Co	hplace (State or Foreign untry) Unk
	9 _		Usual Residence of Decedent			<u> </u>		1 10.10.	1712	
	arytar ehow	_	MD Baltim		City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	the M	Director	19D Dalulii 10e. Street and Number	юге	Parkv	10f. Zip Code		100	J. Citizen of What Co	
	with Sa or	흐	3102 Woodhome	Avenue		2123	/.		.S.A.	and y:
	death	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			Specify Yes or No- to Rican, etc.)	14. Race - Ame	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, if a Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puer Specify:	to Hican, etc.)	Black, White	
21215-0036	ural',	d b	3.≅Widowed 4 □ Divorced	Year or Dates:					WI	nite
꾸	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	6b. Kind of Business/	Industry
7	with iene.	mo D	Elementary/Secondary (0-12)	College (1-4or 5+)		utive S		v F	inancial	Services
ğ	e filed of Hyg other	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma		
<u> a</u>	uld by Wenta Irked Itic e	ToE	Ludwig Pekrul				Anna G	ertz		
lan,	2 sho and le mu		19a. Informant's Name/Relationship (ural Route Number, (
<u>ک</u>	l and fealth im 27 her tr		Lori Kreafle/C	ousin	310:	2 Woodh	ome Ave	nue, Far	kville,	M) 21234 Town, State
פֿר	ages nt of F : If Ite		20a. Method of Disposition 1 ☐ Burial 2 🕏 Cremation 3 ☐		cemetery, crei	matory or otner pia	ce)			
Baltimore, Maryland	artmer ortant Injury		4 Donation 5 Other (Specifical Service Licer)		iesapea	ake Grer 2. Name and Addre	n. UI	.15.08 B	And Fund	e, MD eral Balto
 	Dermi Depa Impo any I		And Ine	Ritter	Α.	lternat	ives 87	17 Green	Pasture	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not ent	ter the mode of dyi	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
i F	hysician		Immediate Cause (Final disease or condition resulting in death)	a HS	CVC					your
	/Medical Examiner		resulting in dealing	Due to (or as a cons-	equence of):					
	₹ ^r	er	Sequentially list conditions, if any leading to immediate	b. Due to for as a cons	actuance of):					
do	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o	Attending Physicien: The law requires that the death certificate be executed redeath. Total Attentities certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Еха	resulting in death) Last	Due to (or as a cons	equence of):					
8760,	ate be hysici the bu	IIcal		d						
X	entifica ding pt	Mec	IF FEMALE:	02- 1					The same	****
Вох 6	res that the death certific igned by the ettending p be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnanc	у		23d. Date of dei Month	ivery Day Year
о. О.	y the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	rueam 5	_ Other (specily) _				
۵.	s that ned b e deta	by Pr	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w requires been sig should be	ed b						1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
ဝ္တ	aw re	plet						24a. Was an	24b. Were au	itopsy findings available completion of cause of
œ ,	ate h	Completed						autopsy performe		
Ħ.	ertific actor,	Be	25. Was case referred to medical examiner?					ath (Check only one)		
d	this c	2	1 Yes 2 No		ER/Outpatier	II 3 DOA		Home 5 Residen		cify)
Division of Vital	After funer	tlon	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ∣Yes 2∐No	28d. Describe how	injury occurred	
ISI.	deatl ctor: y the	flca	2 Accident investigation 3 Suicide 6 Could not be determined		home, farm, sti			28f. Location (Stre	et and Number or Ru	ural Route Number.
É	s after s after al Dire	Certification;	4 Homicide	building, etc. (Spe	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
:	To the Hospital or Attending Physicien: The far within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	withii To the	N	29b. Signature and title of certifier	// //		29c. Licens	e number	290	Date signed (Mont	h, Day, Year)
			14.0/	al			45471		1410	2
	6		30. Name and address of person who	completed cause of death (It	ет 23а) (Туре,	Print)	0 2 11	1		274
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's Sig	La Ha	rtord K	1. Wel-	timore, r	ID al	257
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DHM	IH 17 Rev 1/20	001	JAN 1 5 ZI		0.3					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA al finore Klanded If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12.22.1958 Birthplace (State or Foreign Country) **Funeral** 216.76.9401 49 MD **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 Commerce St. Apt. 1 21078 U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ ₩o Specify: ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within h and Mental Hygiene. 7 Is marked other than ' Elementary/Secondary (0-12) than College (1-4or 5+) Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Kenneth Kilduff, Sr. Lorraine Westphal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any Injury or other trau Donna Marie Kilduff/wife St. 301 Commerst 1, Havre de Grace, MD Apt. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 01.15.08 Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee M01443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final arcinoma unkarun **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

XI

State Registrar

29b. Signature and time of certifier

31. Date filed (Month, Day, Year)

3900

34359 (OHIO)

Raven Boulevard, Baltimore, Maryland 21218

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** KINGER 2008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perrini Balhmin Genesis arkuille If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Virginia Director 229~36~8810 76 27, 1931 Mar. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? within 72 hours after death with 'natural", or items 23a USA Funeral <u>3115 1/2 Garden Ave</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No by Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If Item 27 is marked other than ury or other traumatic event, the M 12 yrs. Bookkeeper Retai] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Blankenship Avis Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri L. Bieneman (Daughter) 817 Corktree Rd. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 1-12-08 Baltimore, Md. 21. Signature_of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, ass Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2nd Stage COPP /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1000 tremi 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1000 , page 2 certificate ! Dm 1□ Yes 2 100 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 1 Inpatient 2 ER/Outpatient 3 DOA After this c 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 31290 11/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chacks 21204 6701 Sur 4>02 Klosse 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Ward.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13, 2008 11:00 A M January Dorothy Clay Kocher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛛 F June 18, 1912 Oklahoma Director 95 579-64-2892 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6104 Wynnwood Road 20816 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Elizabeth Weller John Henry Clay 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6104 Wynnwood Road, Bethesda, MD 20816 Charles P. Kocher/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition January 16, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, Maryland Pumphrey Funeral Home/c. 7557 Wisconsin Ave. 22. Name and Address of Facility Robert A. P Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 Day **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** 1 Day Urinary Tact Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav Year for in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Renal Failure Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acidosis autopsy performed Physician: The 1 ☐ Yes 2 ☐ No certificate 2 X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Injury or Attending 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 13, 2008 D0060117 ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric V. Park, M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year), State Registrar JAN 1 B

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1⊠M 2□F 49 Director 19 1958 218-72-8661 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or and provided the state of th Director Baltimore Nottingham MD 10f. Zip Code 10e. Street and Number 7548 Belair Road 21236 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 🔀 No 1 XNever Married 2 Married 1 ☐ Yes 2 🖺 No Specify 2 and 2 should be filed within 72 hours a leatth and Mental Hygiene.

27 Is marked other than "natural"; or 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin W. Lotz Sr. Margaret K. Volz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin W. Lotz Jr./Brother 7215 Sunshine Ave. Kingsville MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 01/19/08 Parkwood 21. Sig after Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician NOXIC ENCEPHALO PATH resulting in death) /Medical Due to (or as a consequence of): Examiner TATUS CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated event and resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Remote Head Injuries; Extremity and Pelvic Injuries with Complications 1 Tyes 2 Fro 3 Probably 4 Unknown Completed 24a. Was an perforr certificate 1∏ Yes or Vital Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Division or Attending 1 Natural 2 X Accident 5 Pending investigation 2 X No Unknown Unknown 1 TYes Unknown 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Unknown Unknown within 24 hours at Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated.

1- State amend 23a,b, Pt II,27,28a-f per ME g8773,200 Beath

Michael C. Lotz

1. Decedent's Name (First, Middle, Last)

Physician

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20083. Time of Death 0545 A M 80 4c. County of Death Harford Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 ☐ Yes 21 No 10g, Citizen of What Country? 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Electrical 20c. Location - City or Town, State Baltimore MD MD 21236 Approximate Interval Between Opset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) JANUARY 14 ZOOS

2. Date of Death

14

Specify:

01

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea, JAN 1 6

UPPER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapoake Or

CITESAPENKE MEDICAL CENTER

32 Registrar's Signature

Year) 2008

29c. License number

D26344

DEL AIR MITRYLITUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 7:05 PM Eleanor 0retta Lomax 08 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 471 14 5010 88 Director Minnesota March Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10b. County "naturai", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2☐ No Director Virginia Fairfax Fairfax 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 10831 Mt. Vineyard Ct 22032 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 📉 o þ Specify White 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian A. Rogstad Claira A. Holt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Faff (Son In Law) 10831 Mt Vineyard Court, Fairfax, Va 22032 20b. Place of Disposition (Name of Jan 18, 2018 Maryland Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilitee Funeral Home, Inc 6633 01d 21. Signature of Funeral 86 Alexandria Ferry Road, Clinton, MD 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 Other (specify) ed by the a detached for 9 Unknown been signed by t should be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe page 24 No After this certificate Division or Vital 2 No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Man or of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital ...
within 24 hours after death.
To the Funeral Director: Af 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Eleanor

FASTERN SHORE DK, SALISBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Merryman Roxanne /Medical

1 ☐ Yes 2 No if Yes, Give Year or Dates:

College (1-4or 5+)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLAS S

DANIEUE DOBERMAN, MO.

son

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death Day 2008 13, 9:30A Jan. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson <u> Gilchrist Center</u> 8. Date of Birth (Month, Day, Yeer) 07.13.1958 if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗷 F Yrs. 216.72.9638 MD 49 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show notified at 1 | Yes 2 | 100 Director Pikesville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 603 McHenry Road 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status

1□Yes 2⊠No

16a. Decedent's Usual Occupation

Homemaker

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Specify: White

BALTIMORE, MD 21204

16b. Kind of Business/Industry

Own Home

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Zufall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Funeral þ Completed 17. Father's Name (First, Middle, Last) Be 2

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 Divorced

Elementary/Secondary (0-12)

Earl Toomey

19a. Informant's Name/Relationship (Type. Print)

12

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be 1

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed and attending physician for use as the buria signed by the a d be detached f page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, ours after death.
neral Director: A

Division or Vital Records, P.O. Box 68760,

603 McHenry Road, Pikesville, MD 21208 Jeffrey Hofstetter, Jr. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. | 01.15.08 | Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee M0144 Alternatives 8717 Green Pastures Dr., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) UEARS -UNA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. if yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ Ono
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2□No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 200No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D64395 JANUARY 13, 2008

Registrar DHMH 17 Rev 1/2001

State

Registrar's Signature

2 should be filed within 72 hours after death	's after d

The law requires that the death certificate be executed Box 68760 P.0. Division or Vital Records. Physician:

Amend #30, perDVRC875, 1/16/08 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1610 M U Means /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death County of Death Examiner Med Homore HIMOVE ercy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month) Day, Year 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 216-42-4387 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at Director 1√Yes 2 No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 Park Avenue 21202 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) unk t of Health and Mental Hyg If Item 27 Is marked other or other traumatic event, unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 St. Paul Place Baltimore, MD Mercy Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, 4□Donation 5型Other (Specify) in state ice Licensee Signature of Funeral Services State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as gardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mond **Physician** /Medical Due to (or as a consequence of) **Examiner** tastati he Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 50 a 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1□ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 COULD Atlant 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) injury 5 ☐ Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0. 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Oliver Babb, MD Mercy Medical Center Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Division	f or Attend after death Director: /	Certification:	4 Homicide determined	building, etc.		street, lactory, office		City or Town		nai riodio ivambor,
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	Physici	an	1. Decedent's Name (First, Middle, Last) DORIS MERSINGE	- 0			2. Date of De Month	ath Day	Year 2008	3. Time of Death
)	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea			nty of Death	
-	Funeral	. 6	HARBOR HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days		s. 8. Date of Bir	th y, Year)	9. Birthp	place (State or Foreign try) unk
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O. Box	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3]Ectopic pregnancy]Other <i>(specify)</i>				Date of d <i>e</i> live Month	ery Day Year
λ.	requires that the de een signed by the a rould be detached t	by Phy	Part II. Other significant conditions contributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use o	ontribute to the	ne cause of death?
ecord	requipeen s	eted	CONGESTIVE HEART FAILURE HYPERCHOLESTERDLEMIA				1 🗆 24a. Was	Yes 2 No		pably 4 Unknown
ב	The la ate has	Completed	ALL TECHOLES (Elemented)				auto		prior to co death? 1 \(\sum \text{Yes} \)	psy findings available mpletion of cause of 2 No
VItal	ysiclan: Th is certificate director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	EB/Outnatien	t 3 DOA Oth		eath <i>(Check only o</i> Home 5 ☐ Resi		Othor (Coosis	5.4
on or	ding Phy h. After thi funeral c		27. Manner of Death 1 Matural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe			<i>y)</i>
INISION	or Atternation death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At he building, etc. (Specification of the could not be building, etc. (Specification of the could not be building).	ome, farm, stre		res 2 No	28f. Location (City or To		mber or Rura	al Route Number,
	pita burs eral fillec	edical Ce	29a. Certifier (Check only 2 ■ Medical Examiner: On the best of my kno	wledge, death	occurred at the tir	ne, date and place	ce, and due to the curred at the time,	cause(s) and date and place	manner as s	tated.
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of pertifier		29c. License	e number		29d. Date sig	ned (Month,	Day, Year)
			okiccom MD	200\ (T '		ES000		JANUAR	4 02,	2008
			30. Name and address of person who completed cause of death (Item ADEKUNLE OBISESAN 3001 SCUTH HAN:	VER ST	,	LTIMORE	, MD 21	125		1
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signa JAN 1 6 2008		ark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 120 partine 75 of 42 alth and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician QM muary Bertha Matthews /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore naryland General If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 ☐ M 2 🂢 F 67 Feb 19, 1940 217-38-4524 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 N. Gilmore Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: black Specify. þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 11 housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Clinton Jackson Bertha Virginia Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan E. Jones/son 1129 N. Gilmore Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 ₩ Other (Specify) in state Metro Crematory, Inc. 1/24/08 22 Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Euneral Service ROTIATO -21201 299 Frederick Rd. Balto. MD 21228 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed (Rinary Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 ☑ Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 // Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cash the 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 LINDEN AVE RAMESH KUMAR MARYLAND GENERAL HOSPITAL BALL 326 Registrar's Signature MD 31. Date filed (Month, Day, Year) State JAN 1 6 2008 Registrar

Physiciai /Medica Examine Funeral	I MAIL
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Usual Residence of 10a. Street and No. 11a. Marital Status 1 Never Mar. 3 Widowed (Special Street Status) 17. Father's Name 19a. Informant's 1 20a. Method of Dial Burial 2 4 Donation 21. Signature of F
Physician /Medical Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or conditions and the cause of the cause

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, ${\mathcal K}$

ysici: Vedic		HAZE	E L	L.	ME	1ERS				J	Month [13 2008	1256AM
amin		4a. Facility Name (If		HOSE	nd number)	CENS	to "	B. City, Town	or Location	of Death		4c. County of Deatl BALTIT	h .
eral ctor		5. Social Security Nu 214-20-	3797	6. Sex 1 ☐ M 2	7. Age	(In yrs. last b		f Under 1 Ye Jonths Da	ar If Under /s Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Year 12/20/	9. Birtl Co.	hplace (State or Foreign untry)
fied at	tor	Usual Residence of 10a. State	10b. County	timov		10c. City, Tov		ion	1/)				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ust be noti	al Director	10e. Street and Num	ber	oo Km		- Dr		10f. Zip Cod	207	7	10g. (Citizen of What Co	untry?
any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	ed 2∐ Marr	12. Was Arm ied 1 ☐ If Ye	Decedent End Forces? Yes 27 Notes, Give			s Decedent of es, specify C	of Hispanic Or uban, Mexica No Specify:		y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Bl	e, etc.
e Medical E	Completed	(Speci	fy only highe dary (0-12)	t's Education st grade compl	eted) ege (1-4or 5+)	(Give kir life. DO	nt's Usual Oc ad of work do NOT use re	ne during mos ired)	A 8 -	Teocher-	Kind of Business/	Industry
tic event, th	To Be Co	1846 17. Father's Name (I		Last)	9 8001 3	· U	CCITI	THE C	18. Moth	er's Name (F	First, Middle, Maid	len Surname)	
her trauma		19a. Informant's Na	Tyl		Niec	I .	•	•	eet and Numb	er or Rural F	Route Number, Cit	y or Town, State, Z	Zip Code) 5, ID 2111 7 Town, State
Injury or ot		20a. Method of Disport 1 Burial 2 4 Donation 21. Signature of Fur	Cremation 5 Other (S	pecify)	from State	cernet							e funtrus
any lr		. ~ ~ .	gha (e disease, or	complications			84	128 [ibert	y Rd	Ranc		Approximate Interval Between
cian lícal		Immediate Cause (F disease or condition resulting in death)	inal	a. AR	TERID		2 0 T) C	. CAR	DIVVE	1500	lan oi	Stast	Onset and Death
for use as the burial-transit	ical Examiner	Sequentially, liet con- if any, leading to imi- cause. Enter Under Cause (Disease or in that initiated events resulting in death) Li		с	`	consequence							
De l	ysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	nonths?	1	es, outcome p Live birth 2 Pregnant at t Unknown	2 ☐ Fetal dea		ctopic pregna other (s <i>pecif</i> y				23d. Date of del Month	ivery Day Year
uld be deta	ed by Phys	Part II. Other signifi	cant conditi	ons contributin	g to death but	t not resulting	in the unde	erlying cause	given in Part	i.	23e. Did tobacc	co use contribute to	the cause of death?
completely filled in by the funeral director, page 2 should be detach	Completed								-		24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings available completion of cause of 2 \square No
ector,	Be (25. Was case referr examiner?	ed to medica							e of Death (C	Check only one)		
al dire	2	1 Yes 2		Hospital	1 🔲 Inpatien		Outpatient	3 DOW				e 6 □Other (Spe	cify)
the funera	Certification:	27. Manner of Death Natural Accident Suicide	5 ☐ Pendir investi	gation	Date of Injury (Month, Day	Year)	Time of Injury	М	njury at Vork? Yes 2	INo	d. Describe how in		
lled in by		4 Homicide	determ	ined 200.	building, etc.						City or Town, St	tate)	ural Route Number,
npletely f	Medical	(Check only one)	2 ☐ Medical	Examiner: Or and		examination a		stigation, in r	ny opinion, de		at the time, date	e(s) and manner as and place, and due	e to the cause(s)
cor	2	29b. Signature and	mile of certifie	Ne, ~	10		- <u>. </u>		ense number 024	170		Date signed (Mont	
le		30. Name and addre	362,1	who complete	101 0	LO CD	(Type, Pr リれく	int) RDAÉ	RRI	VARLL	-370 WN	MARY	13, 2VT8 LAND 2/133
Sta egistr		31. Date filed (Mont	h, Day, Year) JAN 1	6 2008	32. Registra	r's Signature		2008	,			,	

Registrar

			State of Maryland / Depar State Certification Certificatio	tment of Health and Me ificate of Death	ental Hygier Reg. I	211118	00746					
ľ	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eileen L. Mell		2. Date of Death Jan 11	Day 2008 ear	3. Time of Death 11:00 aM					
	Examin Funeral		1711 Middlebrough Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death ESSEX If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Death Baltimore 9. Birthplace (State or Foreign Country) 1926 Maryland						
	Director tabo	or	217-20-3405		July 6,	, 1920 Ma	10d. Inside City Limits 1 ☐ Yes 2X No					
	3a or 28a- st be notifi	al Director	10e. Street and Number 1711 Middlebrough Road	10f. Zip Code 21221		Citizen of What Co	untry?					
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" are marked other than "natural or items 23a or 28a-f show marked other than Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F □ Yes 2ૐNo Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: V						
21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medical I	ompleted	Completed	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of workir D NOT use retired) maker	ng	Kind of Business/					
Maryland 2	should be filed and Mental Hygi s marked other umatic event, ti	To Be C	17. Father's Name (First, Middle, Last) Howard Leary	18. Mother's Name Lenore	(First, Middle, Maid a Schmid		_					
	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic once.			Address (Street and Number or Rura 5 Gough Street			Zip Code) 21224					
Baltimore,			20a. Method of Disposition 1	atory or other place)	. !	Location - City or Baltimor						
Balti	permit. Departn Imports any Inju		Values of Keny Co	Name and Address of Facility 300 onnelly Funera	l Home c	of Essex						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) a. 20 to (or as a consequence of)	the mode of dying, such as cardiac of Feet January Dra			Approximate Interval Between Onset and Death					
		Examiner	if any, leading to immediate cause. Enter Underlying Cause. Underlying Cause. Underlying	ev-	-							
58760,	ficate be executed physician and is the burial-transit	edical Exar	that initiated events ' resulting in death) Last									
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Δ.	w requires that the debeen signed by the should be detached	by	by	by	by	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobace		o the cause of death? robably 4 □Unknown		
Division or Vital Records,	: The law req cate has beer , page 2 shou	Completed	OF Was associated to Codical		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of					
Ę	Physician: r this certifica ral director, p	o Be	25. Was case referred to fiedical examiner? 1	26. Place of Death	me 5 Residence	e 6 □Other (Spe	cify)					
o uo	nding Ph th. :: After th e funeral	tion: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury 28c. Date of Injury (Month, Day Year) 28c. Time of Injury 28c. Date of Injury (Month, Day Year) 28c. Date of In	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred						
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural R City or Town, State)									
	ne Hospita n 24 hours ne Funeral bletely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the Complete	M	29b. Signature and title of certifier / Care Mally up	29c. License number 29c (83)	29d.	Date signed (Mont	th, Day, Year)					
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	Balto. MD								
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ali s								

			State of Maryland / De	partment of Health and	d Mental Hygi	iene
				ertificate of Death	Re	rg. No. 2008 00747
Æ	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Robert A. Moran		2. Date of Death Month Jan 6, 2	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	eath .	4c. County of Death	
			Southern Maryland Hospital	Clinton		Prince George's
İ	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Mi	in. (Month, Day,	Year) 9. Birthplace (State or Foreign Country) Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
	Maryla f sho led at	ō	Maryland Prince George's	Temple Hills		1 ☐ Yes 2 ☐ No
	r 28a-	irec	10e. Street and Number	10f. Zip Code	10	Dg. Citizen of What Country?
	th with	al D	5010 Thuman Drive	20748	İ	United States
	tems er mu	Funeral Director	Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "battral Examiner must be notified at matic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 M2 Yes 2 ☐ No 1951 1 Yes, Give 1952 1 Yes or Dates: 1952	1 ☐ Yes 2 ☐ No Specify:		Specify:
215-0036	2 hou atura cal E	ted	15 Decedent's Education 16a. De	XX ecedent's Usual Occupation	10	White 16b. Kind of Business/Industry
712	filed within 72 Hygiene. Ather than "nai Ather the Medica	Completed	(Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4or 5+)	tive kind of work done during most of v e. DO NOT use retired)	l.	
7	filed wi Hygien other th			eman		Public Safety
Maryland	buld be fil Mental H arked ott atlc even	Be	17. Father's Name (<i>First, Middle, Last</i>) Henry Lewis Moran, Jr.		lame (First, Middle, M Norfolk	faiden Surname)
Ž	es 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic e	은		ailing Address (Street and Number or		City or Town State Zin Code)
	and 2 sealth ar n 27 Is ser trau		1 1 7 7	010 Thuman Drive,		, , , , , ,
e,	es 1 a of Heg		20a. Method of Disposition 20b. Place of Di	sposition (Name of		20c. Location - City or Town, State
Ē	Pages nent of I ant: If ite ury or o		A Surial 2 Gremation 3 Gremoval from State	1 Veterans Cemeter		Cheltenham, Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Liconsee	22. Name and Address of Facility $L_{ m c}$	eé Funeral	Home, Inc 6633 01d
	U. K. Savis		231 Pan . Enter the disease, or complications that caused the death. Do not	Alexandria Ferry enter the mode of dying, such as card		est. Approximate
Ē	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	LOTIC CARDIC	NASCURA	Initierval Between Onset and Death
	n =	ner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c			
8/60,	be exician a	alE	Due to (or as a consequence of):			
2	ficate physis the	edical	d			
C. B0X	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Ţ.	that the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
ds,	The law requires that the te has been signed by the age 2 should be detache	d by	PULLONARY ELEPOUS		1 <u></u> Ye	The state of the s
Hecord	s beer	Completed			24a. Was an	24b. Were autopsy findings available
	The lav	omp			– autopsy perform 1□ Yes 2	y prior to completion of cause of
VITal V		BeC	25. Was case referred to medical	26. Place of [Death (Check only one	
0 <	Physician: this certific al director,	ToE	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpa		g Home 5 Reside	nce 6 ☐Other (Specify)
			27. Manner of Death 1	ry Work?	28d. Describe ho	w injury occurred
UNISION	ten tor the	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm	M 1 Yes 2 No	28f Location /Str	reet and Number or Rural Route Number,
2	al or Attendates after death	Certification:	4 Homicide determined building, etc. (Specify)	street, ractory, office	City or Town	
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dependent on the past of examination and/of and manner stated.			
	vith To 1	Σ	29b. Signature and title of certifier	29c. License number	1000	9d. Date signed (Month, Day, Year)
!	/X\		1/100	11-182	12)	muny 1, 2008
7)1		30-Nayfie and address of person who completed cause of death (Item 23a) (Ty	DEB LINE CEN	OVEN INS	ALBOXF, Id. 2008
	Sta	te	31. Date filed (Month, Day, Year) 32: Registrar's Signature	1 3	J. J. C. W/	1000
	Registr		JAN 1 6 2003 June 18	3543		

08-00303 Kenneth Moss Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nneth Moss	1-	St:	nd / Depar	Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 007									
Physicia	Re	egistrar . Decedent's Name (First, Middl				2 Date of De	ath			e of Death)4 hrs			
edical Examin	er	4c. County of Land (if not incitiation, give street and number) 4b. City, Town, or Location of Death							tc. County of Dea	ath			
		809 Jack Street				Baltimo			Hrs. 8. Date of I	Pleth (A 4	N/A	Birthnlace	(State of
Funeral Director	5	5. Social Security Number 423 21 4879	6. Sex	st birthday) Yrs	If Under 1 Months	Year Days		Min. 05/0			eign Country)	Germany	
'n	Usual Residence of Decedent					on							nside City Limits
Maryland 28a-f show any d at once.			N/A	В	altimor	`e							Yes 2 No
hours after death with the Maryland "natural", or items 23a or 28a-f sho <u>Examiner must be notified at once.</u>	Director	10e. Street and Number 10f. Zip Code 21225							10g. C	Citizen of What C			
vith the s 23a or		11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13. Wa	s Decedent	of Hisp	anic Origin?	(Specify Yes or erto Rican, etc.)	No-	14. Race - An White, etc		tian, Black,
	Funeral	1 Never Married 2 XN	Armed Formation 1 Yes vorced If Yes, Give Yea	2 X No	1 1	Yes 2			one thous, ever,		Specify:	31ack	
urs after tural",	<u>a</u>	Widowed 4 Di 15. Decedent's Education (Spr			16a. Deceder		ccupatio	on (Give kind	d of work done e retired)	16	o. Kind of Busine	ss/Industr	у
136 thin 72 hours after ne. than "natural", ledical Examiner	ompleted	Elementary/Secondary (0-12 12th) College (*	1-4 or 5+)	_	rehou	sema	an			Warehou	ıse	
5-06 led wi tygien other	e Com	17. Father's Name (First, Middle	e, Last) Robert Lee	e Moss	l ·-			0	Name (First, Midd thell Gr	rego	ry		
2121 hould be fil and Mental I is marked atic event,	m l	19a. Informant's Name/Relation				g Address Jack S			rorRuralRoute	Number	, City or Town, S Marylan	state, Zip C rd 217	225
mand 2 shoul fealth and N tem 27 is in traumatic	1	Shirley Moss 20a. Method of Disposition			Place of Dispo	sition (Name			Date		0c. Location - Cit	ty or Town	State
MOFE		1 Burial 2 XCrematic			crematory or o	Crema			01/21/20				Maryland
Baltimore, MD permit. Pages I and 2 sho Department of Health and I Important: If item 27 is injury or other traumat		21. Sign and of Funeral Service	ce Licensee	nida		Name and A	itcl	nie Hi	ghway I	Balt	ral Servimore, 1	Maryl	and ZIZZS
Physician		23a. Part I. Enter the disease, failure. List only one caus	se on each line.			the mode of	dying,	such as card	diac or respirator	arrest,	, shock, or heart	Ap Be	proximate Interval etween Onset and Death
aminer		Immediate Cause (Final diseasor condition resulting in death)		a consequence								1	
	-	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	of):								
- W.	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Las	Due to for no	a consequence	of):								
e executed cian and	al Ex		d										
ਰ ਜ਼ੋੜ	ledical	UNPENDED IF FEMALE:	AMENDED	s, outcome of pre	egnancy					_	23d. Date of de		Vasa
Box 68760, cleath certificate be the attending physic ed for use as the bur	sician/Me	23b. Was decedent pregnant in past 12 months?	n the 1 Live	e birth gnant at time of c	2	Fetal death Other (Spec	3 cify)	Ectopic	pregnancy		Month	Day	Year
Box e death the atter	Physic	1 Yes 2 No 9 Part II. Other significant con	Unknown g Unk	known				oiven in Par	t I. 23e.	Did tob	acco use contrib	ute to the	cause of death?
, P.O. ires that the signed by	€		aitions contributing	to death but not	resulting in th				1	Yes	2 No 3	_	
ords, w require s been si s been si	Completed									Was ar autopsy perform	y pri	ere autops for to comp eath?	sy findings available pletion of cause of
Reco The law icate has	J WOS						26 Plac	e of Death (Yes 2		✓ Yes	2 No
ital Recipions: The scertificate rector, page	Be	25. Was case referred to med examiner?	Hospital: 1	Inpatient 2	ER/Outpati	-	DOA	Other ₄	Nursing Home	5 R	Residence 6	Other: So	ene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	on: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 F	28a. Da (Mo Jan 1	ate of Injury onth Day Year) 1, 2008	28b. Time 1103 hrs	of Injury	_	ury at Work' Yes 2	Subject	cribe ho t shot	ow injury occurre self	d	
ivisior or Attenct after death Director:	ertification:	2 Accident II	nvestigation 28e. P	lace of Injury - A			y, office	building, etc	or T	ation (Stown, Stoke Street	treet and Numbe ate) et, Baltimore, M	r or Rural	Route Number, City
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Cer	29a. Certifier		best of my knowl	1 - 1 - 1 - 1	a was a st th	e time,	date and pla	ce and due to th	e cause	e(s) and manner	as stated.	ause(s)
The second of th							on, death oc nse number	curred at the time	29d. Date signe		, Day, Year)		
•	≥ 1.29b. Signature and title of certailer								January 12	, 2008			
H	30. Name and address of person who completed cause of death (Item 23a)												
	State	Donna M. Vincenti	(ear) 32	Registrar's Sign		and I							
Regi			0 2008 4	10 0	10 for	The State of the S							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month AM**Physician** January 9, 2008 9:50 E. Morgal /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Potomac Rebecca House if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 11X M 2 □ F October 4, 1920 Maryland 87 **Director** 579-12-7622 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Cabin John Maryland| Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20818 6520 76th Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ Year or Dates: 1943-1945 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Foreman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha E. Beall David L. Morgal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6520 76th Street, Cabin John, Maryland 20818 Mary M. Morgal / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 15 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service M01473 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4 Days **Physician** Cellulitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Infected Sebacious Cyst Neck Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician end for use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown Dementia, Multi Infarct Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 performe The 1 Yes 2X No certificate or Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 Ill Inpatient 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division or Attending 1 Natural 5 Pending 1 ☐ Yes investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler January 14, 2008 dress of person who completed cause of death (Item 23a) (Type, Print) and a 10215 Fernwood Road, #100, Bethesda, Maryland 20817 M.D. Thomas McNamara,

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Registrar's Signature

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

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Morgan James M			ate of M	aryland /		rtment of		and	Menta	al Hyg	giene	3			
		For State Certificate of Death Reg. No. 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2									12 0075				
Physicia Medical Examir											Year	0630 hrs			
Medical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death										County of Deat	h		
		514 Crabb Avenue	. 5	·			Rockvill	е				M	ion tgomery	nty of Death gomery YYY) 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 X Yes 2 No f What Country? States Race - American Indian, Black, White, etc. ify: White of Business/Industry Alarm anology ame) Town, State, Zip Code) fland 21771 tion - City or Town, State kville, Maryland rey Funeral Rome/ mery Avenue	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under		If Under	_	8. Date of B	irth(MM/I			
Director		216-19-8701	1 X M 2	F	29	Yrs	Months	Days	Hours	Min.	Novemb	er 15	,1978	ountry) Maryland	
		Usual Residence of Decedent													
- w m		10a. State 10b. County			10c. City,	Town or Locati									
1291 Maryland r28a-f show any	ţ	Maryland Montg	omery			R	ockvil					10- Citie	rop of What Cou		
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ours a atura xami	d b	15. Decedent's Education (Spe		_		16a. Deceden	t's Usual Oc					16b. k	Kind of Business	/Industry	
16 n 72 h	Jete	Elementary/Secondary (0-12)	Co	llege (1-4 or 5	i+)								Fire Alarm		
003 withi giene.	Complete	17. Father's Name (First, Middle	Last)			Denizor				First, Middle			зу		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	o l	Edward V. Man						"			nce L.				
212 ould bould be mark	9 B	19a. Informant's Name/Relations		nt)		19b. Mailing	Address	(Street						te, Zip Code)	
MD d 2 shc lth and n 27 is		Charles W. Mi	tchell	/Broth	er	1311	3 Mano	r D	rive	, Mt	. Airy				
t te ea a :		20a. Method of Disposition 1 X Burial 2 Crematio	a 3 Der	noval from Sta	امد	Place of Dispos crematory or ot	ner place)		etery,	Janu	ary 1	1			
Baltimore, permit. Pages la Department of He Important: If ite		4 Donation 5 Other S		novar nom oa	Par Par	rklawn l k				2008					
Salti ermit. epartr nport ijury		21. Signature of Funeral Service	Licensee		10-5	22. N Ro	lame and Ad	dress o	of Facility Inc.	3 e 3 0	rt A. West	Pump	hrey Fu	ineral Home/ Avenue	
	4	23a. Part I. Egler the disease, o	Kut	a that aguad	MO1	498 Ro	ckvill	e,	Mary	Land	20850	rrest shr	ock or heart		
Physician /Medical		failure. List only one cause	on each line			. Do not enter t	ie mode or	ayırıg, s	doi: 23 ou	idido oi	respiratory a	most, site	Jok, or mount	Between Onset and	
aminer	the state of the control of the state of the														
		Sequentially list conditions,	b	`											
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Box 68760, e death certificate be the attending physicited for use as the burined for use a	cian/Me	IF FEMALE: 23b. Was decedent pregnant in t	23c.	If yes, outcor	ne of preg	,	tal death	3	Ectopic	pregnan	cv	23	 d. Date of delive Month 	Day Year	
x 68 h cert	icia	past 12 months?	4	Pregnant at	time of de	noth =	her (Specif			3		- 1		,	
Box e death of the atten	Physi	1 Yes 2 No 9 Ur	13	Unknown							100	9			
that the red by detach	by P	Part II. Other significant condi	tions contril	outing to deat	but not r	resulting in the	ınderiying c	ause gi	ven in Par	t I.				to the cause of death?	
cords, P.O. law requires that the has been signed by 2 should be detach		Cocaine Use								_	24a. Wa			autopsy findings available	
OCC law re has be	ple						.				aut	opsy formed?		completion of cause of	
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n of Viding Physical Characteristics	2	1 ✓ Yes 2 No 27. Manner of Death		a. Date of Inju	ry	28b. Time of		<u> </u>	at Work?		-		ury occurred	ier. ocene	
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Division tal or Attendi rs after death. al Director: /	fica		estigation 28	Be. Place of In	jury - At h	nome, farm, stre	et, factory, o	office bu	ilding, etc				and Number or F	Rural Route Number, City	
The standing of the standing o															
at 4 d light one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and grand manner stated.								use(s) ar	nd manner as st	ated.					
									29d. Date signed (Month, Day, Year)						
	Σ	29b. Signature and title of certif	er ,			7		License O.C.N				1	nuary 9, 200		
		MUNI	e		noth //d	7 ()		J.J.1V				Jul	5, 200		
FA		30. Name and address of person who completed cause of death (Mem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
St	ate	31. Date filed (Month, Day, Year JAN 1	2000	32 Registra	r's Signat		ida s				OCME				
Regist	rar	JAN I	2008	Allanda	and fine	No. of Street,	4)419								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 4:40 AM Richard Charles O'Toole January 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery Derwood If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. 85 Director 219-12-0307 06/04/1922 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905-14710 Peach Orchard Road USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 Divorced Year or Dates: WW II White Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Telecommunication Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John O'Toole Lillian B Mayne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Case/Daughter 12930 Clarksville Pike Clarksville, MD 21029-Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan 16 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 Shell Johnson Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiosespe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed the burial-transit Box 68760, lobable and Due to (or as a consequence of): ovascular discore nding physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the sold be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Year) 1 🛮 Natural 5 Pending investigation neral Director: A 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ARU MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Princephy GH \$ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** PEACOCK-DAVIS JANUARY 11:17 10 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Johns Hopkins HOS DITO 8. Date of Birth 11/07/1995 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 X M 2 □ F 12 219-45-0233 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes No Baltimore Directo Maryland Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21221 2311 Bauernschmidt Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite Never Married 2 Married 1 ☐ Yes XXX No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Peacock Heather Davis ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 Bauernschmidt Drive, Baltimore, Maryland 21221 Edward Peacock (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ment of H ant; If ite ury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 01/15/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death heart failure. List only one cause on each line. Immediat - Cause (Final disease or ondition resulting in death) Physician Bilineage Leukemia 15 months /Medical Due to (or as consequence of): Examiner Failure Kespitatory Sequentially list conditions, it any, it admits to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Sepsis resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, funeral director. the Hospital or Attending after death. the

Saltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 🔲 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 2008

State Registrar

within 24 hours a

Medical

HICHAL

31. Date filed (Month, Day,

JAN

600 N. Wolfe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPAEDER

Year)

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32. Registrar's Signature

A Part

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 0521 Peterson cob 0 Jan. 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Baltimore UMMC If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Months Days 1 StM 2 □ F S.C. 215-62-1796 1939 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1X Yes 2 □ No N/ABaltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21224 U S A N. Kenwood Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Merried 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working Unk life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Unk Elementery/Secondary (0-12) College (1-4or 5+) 9th grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Dora Peterson Early Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1109 N. Stockton Street Balto, MD 21217 Anthony Peterson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-17-08 Randallstown, MD King Memorial Park 21. Signature of Function Service Licenses 22. Name and Address of Facility March F/H East MD 21202 North Avenue Balto, 1101 E. 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatiz nostate CA Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

10

Funeral

Director

e filed within 72 hours after deeth with the Maryland at Hygiene. other than "natural", or itema 23a or 28a-f show

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or itema 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

f Health and Mental

Pages 1 and 2 s ment of Health an

Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funaral director, page 2 should be datached for use as the buriel-trensit edical Certification: To Be Completed by

25. V

29a. Certifier

Attending Physician: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Ves case referred to medical				26. Place of
ixeminer?	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	
Inner of Dooth	28a Data of Injury	29h Time of	280	Injuny et

Death (Check only one) ng Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth 1 Avaturel 2 Accident	5 Pending investigation	28e. Dete of Injury (Month, Day Y
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury building, etc. (

28d. Describe how injury occurred Work? 1 ☐ Yes

a To a second		
6 ☐ Could not be determined	28e. Place of Injury - At home, ferm, street, factory building, etc. (Specify)	, offic

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)	2 ■ Medical Examiner: On the basis and manner s
29b. Signeture an	tiple of certifier
► //	(asta mi

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

1 🗡 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

Sta	ite
Dominto	

31. Date filed (Month, Day, Year) 16

s. Greene St Baltimore 32. Registrer's Signature

within 24 hours a

08-00219 Michelle Rinehart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 00754

		- For State	Certific	cate of L	Death			g. No.		3. Time of Death
Physicia		egistrar I. Decedent's Name (First, Middle,Last)					2. Date of Death Month January 8,	Day	Year	0755 hrs
ران 'Examin	ner	Michelle Karen R	inehart				January 8,		nty of Death	
i j		4a. Facility Name (if not institution, give stre	et and number)	4b	. City, Town, or Lo	ocation of Death			· .	
*		2508 Druid Park Dr.			Baltimore				I/A	Indiana (Chata an
F	-	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Birt	h(MM/DD/Y	Foreig	hplace (State or n New Jerse) untry)
Funeral Director		217-76-4886 ₁ M	× 5 49	Yrs.	Months Days	Hours Min.	Dec.	23 , 19	158 coi	untry)
Director	L		Z	110.						
		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Location	on .					10d. Inside City Limits
v an	- 1			timo:					1	1XX Yes 2 No
and show	히	Maryland N/A					11	Oo Citizen o	of What Cour	ntry?
aryla aryla at or	햜	10e. Street and Number			10f. Zip Code		Ι.			,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	2508 Druid Park	Drive		21215			USZ		Di-at-
with the Maryla as 23a or 28a-fi			. Was Decedent Ever in U.S.	13. Was	Decedent of Hisp es, specify Cuban,	anic Origin? (S	pecify Yes or No		Race - Ameri White, etc.	ican Indian, Black,
ath v	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 X No	IT YE	es, specify Cuban,	Mexicall, Facility	, radam, every		D.1	a ale
er de		3 Widowed 4 Divorced If Ye	es, Give Year		Yes 2X No				cify: B1	
s aft rral"	þ	15. Decedent's Education (Specify only hi	lates:	a. Decedent	's Usual Occupation	on (Give kind of	work done	1	of Business/	
hour mate	Completed		College (1-4 or 5+)	during mo	ost of working life.	DO NOT use re-	irea)	Balt	cimor	e City
)36 thin 72 re. than "	읦		Year	offi	ce Assi	stant		Pub	lic S	chools
5-0036 led within 7. Hygiene. I other than	팀	17. Father's Name (First, Middle, Last)			1	8.Mother's Nam	e (First, Middle,	Maiden Sur	name)	
15-00 filed with Hygien d other						→ Evel	lyn Rineha	art		
121 l be fi ental l arked	Be	Charles Shaw 19a. Informant's Name/Relationship (Type,	Drint \	19b. Mailing			Rural Route Nu	mber, City o	r Town, Stat	e, Zip Code)
D 21215-003 should be filed within and Mental Hygiene. T is marked other the natic event, the Meg	To			9775	Fontana	a Lane	Baltin	nore,	Mary	Land 21237
MD od 2 shouth and m 27 is aumati	1	Shaneka Hall Al-	Saidi I'	ce of Dispos	ition (Name of cer		Data	200 1003	ation - City o	r rown, State
ore, MC es I and 2 sl of Health an Hitem 27 her traums		20a. Method of Disposition 1 Bunal 2 Cremation 3	200.1100		- ar alaga)	1	/16/08	Wood	lawn	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Operatment of Health and Mental Hygiene. Important: If frem 27 is nawked other than "natural", eliquity or other traumatic event, the Medical Examiner:			Moo		Cemet	- 1				
it. Partime		4 Donation 5 Other Specify: 21. Signature of Funeral Service License		22. N	lame and Address	of Facility Ch	atman-	Harri	s Fu	neral Home
Baltimo permit. Page Department (Important: injury or ott	1	The Call		1 - 4	240 Dei	atoret	own Rd	ватт	THIOT	e, Ma 21213
	1	23a. Part I Enter the disase, or complica	tions that caused the death. Do	o not enter t	he mode of dying,	such as cardiac	or respiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
Dhysician adical		fair re. List only one cause on each	^{line.} ardiac arrhythmia	_ Monin	ocencenhal	itis				Death
amine		Immediate Cause (Final disease a.	ardiac aimyumua	1 1211111	gociccpian	1010				
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death) Due	e to (or as a consequence of):							
	1_	Sequentially list conditions,	e to (or as a consequence of):							
	Examiner	cause. Enter University Cause	, to for do a consequence en							
11	a E		e to (or as a consequence of):							
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760, icate be a physicia the burie	<u>g</u>	IF FEMALE:								* *
776 ficate g phy	\}	23b. Was decedent pregnant in the	1 Live birth	2 F	etal death 3	Ectopic pres	gnancy	М	lonth	Day Year
Sox 687 leath certific e attending	ia l	past 12 months?	4 Pregnant at time of death		ther (Specify)			- 14		
Box 687 e death certific the attending	Ś		9 Unknown							to the cause of death?
ords, P.O. B w requires that the d is been signed by the	Physician	Part II. Other significant conditions	ontributing to death but not res	ulting in the	underlying cause	given in Part I.				Probably 4 Unknown
P.O.	ھ ا	Human Immunodeficien	cv Vinus				_ 1 _ '	Yes 2		
S, quire an sig	1 2	Transpir Timenoger Terre	<u> </u>				24a. W	as an topsy	24b. Were	autopsy findings available to completion of cause of
w rec							pe	rformed?	death	1?
ecc he la	Completed by	i .		*				s 2 No	1 🗸	Yes 2 No
tal Rection: The	ن اجَ				26.Plac	ce of Death (Che				
Vita hysician this cer			spital: 1 Inpatient 2 E	ER/Outpatie	nt 3 DOA	Other Nu	rsing Home 5		ce 6 🗸 O	ther: Scene
Phy Phy	E E	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o	f Injury 28c. In	jury at Work?	28d. Descri	be how injur	y occurred	
n of	E 8	1X Natural 5 Pending	(Month, Day, Year)		1	Yes 2 No				
Division of Vital Records, P.O. nat or Attending Physician: The law requires that the rest after death and Director: After this certificate has been signed by the death of the control of	ž t	2 Accident Investigation	28e Place of Injury - At hor	me, farm, sti	reet, factory, office	e building, etc.			d Number or	r Rural Route Number, Cit
Vis or A after Dire		3 Suicide 6 Could not be determined	(Specify)				or Tow	n, State)		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending	completely filled in by the runeral director, page z	4 Homicide		- 45-41	viscod at the time	date and place	and due to the	ause(s) and	manner as	stated.
Hospital 24 hours Funeral	etely		n: To the best of my knowledge On the basis of examination an	e, geath occ id/or investig	curred at the time, pation, in my opini-	on, death occurr	ed at the time, d	ate and place	e, and due f	to the cause(s)
To the To the To the	complete		on the basis of examination and manner stated.	IIIveali				29d D	ate signed	(Month, Day, Year)
F. ≥ F.	2 2	29b. Signature and title of certifier				nse number				
		Vandel Kar the 11	MA		0.0	C.M.E.		Janu	ary 10, 2	.000
	1	30. Name and address of person who co	ompleted cause of death (Item	23a)						
5	-	Pamela E. Southall, MD	Assistant Medical Exar	miner 1	111 Penn Stre	eet, Baltimor	e, MD 2120	1		
		at Salating Salating								
	Sta	9 25 5 7 7	32. Registrar's Signatur	A. A	med					
900	iistra	TEATH I IN C.	A Contractor A	57						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 10:37P M 07, 2008 LUCY ANNE RICE JAN. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 😿 F Yrs. 4/17/1925 82 VIRGÍNIA 202-22-8452 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show ral", or items 23a or 28a-f shov Examiner must be notified at 1**XX**Yes 2 ☐ No Director MD N/A BALTIMORE CITY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5029 GWYNN OAK AVENUE 21207 USA Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status filed within 72 hours after (Hygiene. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No BLACK Specify: Completed by Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th and Mental Hygiene. College (1-4or 5+) HOMEMAKER DOMESTIC 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If Item 27 is marked oth Be BILL NELSON RUTH RICHARDSON ဂ္ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7312 ROCKRIDGE ROAD, BALTIMORE, MD 21207 ROBERT G. RICE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of P Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEMETERY 01/14/08 BALTIMORE CO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 21207 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme fall Cause (Final meer mother Physician r condition resulting in death) /Medical Due to (or as a consequence 3) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has performe death? 1 ☐ Yes 2 □ No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ₩ 3 Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician;

after death. in by the within 24 hours a To the Funeral L completely filled the

Medical

State Registrar

29c. License number)25205

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

N. Chules St. Balts. UN 21203

31. Date filed (Month, Day, Year) 6

4 Homicide

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of W	arylari	•	ertificate of			Reg. No.	008	007	56
b	Physici	an	1. Decedent's Name (First, M Rose Dalton R		st)					2. Date of Dead Month		2008°	3. Time of 5:49	Death aM
	/Medic		4a. Facility Name (If not instit		re street and number)		4b. City, Town, o	r Location of Death	January	_	ounty of Death	3.15	QIWI
-	LXaiiiii	CI	Franklin Squa	_				Roseda				ltimore		
	Funeral Director		5. Social Security Number 219–18–0519		Sex 7. A 1 □ M 2 XX	ge (In yrs. 84	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date 10/08/1	h y, Yea <i>r)</i> 1923	Coun	place (State of htry) yland	r Foreign
	land ow it		Usual Residence of Deceden 10a. State 10b. Con			10c. Cit	y, Town or L	ocation				1	0d. Inside Cit	y Limits
	a-f sh	ctor	Maryland Bal	timo	re	Mid	dle Ri	ver					1 ☐ Yes	2 XX lo
	ith the	Funeral Director	10e. Street and Number 7 Floral Plac					10f. Zip Code				en of What Cour	ntry?	
	eath v ns 23a must	eral	11. Marital Status		12. Was Deceden	t Ever in U	.S. 13	21220 Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No		U.S.A. I. Race - Americ	an Indian,	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 223 3 Widowed 4 Divo		Armed Forces 1 ☐ Yes ※ If Yes, Give Year or Dates:	?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 223No	an', Mexican', Puèrto Specify:	Rićan, etc.)		Black, White, Specify: Wh:	_{etc.} ite	
21215-0036	72 ho "natur dical I	Completed	15. Dece (Specify only h	dent's E	ducation ade completed)		16a. Dec	edent's Usual Occup e kind of work done	nation during most of work	king	16b. Kind	d of Business/Ind	dustry	
121	within ene. than '	dmo	Elementary/Secondary (0-	2)	College (1-4or 5+	5+)	(Give kind of work done during most of work life. DO NOT use retired) Teacher			Edi	ucation			
<u>5</u>	e filed Il Hygi other /ent, tl	Be Co	17. Father's Name (First, Mic	dle, Lasi			1000		18. Mother's Nam	e (First, Middle,				
<u>ylar</u>	Mental Mental arked o	To B	George Samuel	Dal	ton				Cather:	ine Wagr	ner			
Maryland	12 shoth and 7 is mutraum		19a. Informant's Name/Relati Robert Ross (1	ling Address <i>(Street</i> Loral Plac			-	•		
	s 1 and Health tem 27 other tr		20a. Method of Disposition	iusu	and)	20b. F	1	osition (Name of ematory or other place	•	Date Date		ation - City or To		
Baltimore,	Pages ment of I ant: If ite		XXBurial 2 □Cremat 4 □Donation 5 □ Othe				lair N	Memorial (ard 01/10			Air, Ma		
Ball	permit. Page Department of Important: If any injury or		21. Sign ti re of Funeral Ser	ice ice	nsee	_		22. Name and Addre Br 1407 Old	ruzdzinsk: Eastern <i>I</i>	i Funera Avenue,	al Hor Esse:	ne, P.A. x, Mary	iand 2	1221
þ				, or com List only	plications that cause one cause in each	ed the deat line.	h. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Bet Onset and I	e ween
1	Physician /Medical		23a. Part1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause, n each line. Immeriate Cause (Final disex e or condition resulting in death) a.											
	Examiner		92		Due to (or a	s a conseq	uence of):	5.		2.0				
F	7 ±	ner	Sequentially list conditions, if any, leading to in reduce cause. Enter Underlying Cause (Disease or injury that is in the cause)	J	b. Due to (or a	s a conse	uence of):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c Due to (or a	a consen	nence of).							
68760,	tificate be executed g physician and as the burial-transit			l	. d	<i>3 a 001100</i> q	301130 01).							
		fedical												
). Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician//	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	138	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	death 3	□Ectopic pregnanc □ Other (specify) _	у		23	d. Date of delive Month		Y ear
P. 0.	ires that the de signed by the a be detached t	Phy	Part II. Other significant con	ditions	contributing to death	but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use	e contribute to the	he cause of d	leath?
rds	quires n sign uld be	d by	_							1 🗆 🕻	Yes 2	No 3 □ Prot	oably 4 □ l	Jnknown
Records,	e law require has been sig je 2 should b	Completed								24a. Was		24b. Were auto	ppsy findings a	available ause of
											performed? death?			
Vita	sician; Th s certificate lirector, pag	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No	lical	Hospital:	iant 25	EB/Outpatie	ent 3 DOA Oth	26. Place of Deather:			□Other (Specif	6.1	
יס ר	ding Phys n. After this funeral di		27. Mann Death		28a. Date of In	jury	28b. Time Injury	of 28c. Inju		28d. Describe			(У)	
Sior	endin eath. or: Af	atio	Z L / (CCIGCIII	nding estigatio uld not b	n			M 1 □	Yes 2 □ No					
Division or	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:		termined	28e. Place of II	njury - At h etc. <i>(Specii</i>	ome, farm, s	treet, factory, office		28f. Location (3 City or Tou	Street and vn, State)	Number or Rura	al Route Num	nber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in L	Medical			hysician: To the bes miner: On the basis and manners	of examina								3)
	To the To the Comp	Ž	29b. Signature and title of ce	tifier	An) - 17	0,		29c. Licens	1 Day		1	signed (Month,		
)	/		1/lane		11000	1	w	U2	600			4101		
	5		30. Name and address of pe	son who	VAS C	pano	es	s, Print) STreet	- July	313, 1	Belle	ylos	w 21	204
	Sta Registr		31. Date filed (Month, Day,	ear)	32 Regis	trar's Signa	ature	and I		,				/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death O Nonth **Physician** Pay 4 2008 Richard Allen Russ 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 1744 W. Old Liberty Rd., Apt. 3 Westminster 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month Day Year) 6/16/1945 Days Hours 1 **X**M 2 □ F MD Director 213-54-1071 Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1744 W. Old Liberty Rd. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married þ 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Welder Metal Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Russ, Sr. Edith Gertrude Jolley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Schultz Russ/Wife 1744 W. Old Liberty Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 1/15/2008 Winfield, MD 21. Signature of Puneral Service Licensee Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nset and Death **Physician** ance 1048415 /Medical Due to (or as a consequen of): Examiner Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death Check only the Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes ို 2 ER/Outpatient 3 DOA For Residence 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2057

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 10, **Physician** 2008 Saac Jun /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hou 2614 Hospital General Counts Year If Under 24 Hrs. 8. Date of Birth 12/17/1922 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** PA 85 286-20-5772 1**½** M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1X Yes 2 No **Plantation** FLBroward Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33324 USA 10097 Cleary Boulevard by Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) Sales Self Employed 12 Pages 1 and 2 should be filed and the filed and Mental Hygis int; If item 27 is marked other Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Reid Williamson George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10097 Cleary Boulevard, Plantation, FL 33324 19a. Informant's Name/Relationship (Type. Print) Reid / Wife Elizabeth altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₩Burial 2 Cremation 3 Removal from State 1/15/2008 Cincinnati, OH Spring Grove Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. oughai East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** theomonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as by the attending ached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Corona 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death after death.

i Director: After the in by the funeral Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funerail 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier

State Registrar

De lean C.FL/e 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) January 11, 2008 12:32pv Wendell Robinson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George Medical Center Cheverly If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 TN 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth 09707/1921 1 → M 2 □ F 413-18-2812 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count TN Hamilton Chattanooga TXXYes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 37406 USA 3424 Persimmon Street 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married **Black** 1 ☐ Yes 3 € No Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jack Robinson Ida Mae (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8002 Hunter Drive, Clinton, MD 20735 Karren Torres / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation ③ Removal from State National Cemetery 1/16/2008 Chattanooga, TN 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home In 1501 East Fort Avenue, Baltimore, Home Inc W. Mayshan MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Coronary Syndrome Due to (or as a consequence of): Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequence of) Dementia If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 DUnknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20XNo 2 No 1□ Yes 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 XNo 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or 3

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any fujury or other traumatic event, the Media once.

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Indicate the continuation of the attending physician and stell filed in by the funeral director. After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital within 24 hours at To the Funeral D

Physician/Medical

Completed by

To Be

Certification:

Medical

31. Date filed (Month, Day, Year)

JAN 1 6 2008

Division or Vital Records, P.O. Box 68760, 以

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald C. George, M.D. Hospital Drive, Cheverly, MD 20785

State Registrar 32. Registrar's Signature

D58182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:04 PM **Physician** Royster 4008 James Edward January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Doctor's Hospital Lanham 8. Date of Birth (Month, Day, Year) Tully 1,1932 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 € M 2 □ F South Carolina 75 **Director** 251-46-5010 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 ☐ Yes 2 📆 🖈 lo Director Maryland Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 7409 Clinton Vista Lane 20735 items 23a ir than "natural", or items 23a the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☐ No 1951— If¥es, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White 2 3 Widowed 4 Divorced Baltimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 1/2 Purchasing Agent Clark Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, ## 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be White Horace Royster ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Royster (Wife) 7409 Clinton Vista Lane Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan Pate 11. 1XIBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Maryland Veterans Cem. 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Liganisee 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 415 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY 10 415 Arterial Sequentially list conditors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit End Stage certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buna Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deal 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? res 2 No certificate 1∏ Yes Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. I Division or Vital Records,

To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARHAN

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JA MALI MI)

32. Registrar's Signature

7305

Hanover PKny

29d. Date signed (Month, Day, Year)

State Registrar

Medical

DHMH 17 Rev 1/2001

Beck

1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2002 851 3

Sandy Spring

8:25 PM

Montgomery

Brooke Grove Rehab. & Nursing Center

If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 X M 2 □ F 77 September 23,1930 Ohio Director 287-28-7800 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show 1 □Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 3100 N. Leisure World Blvd., #421 20906 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Research and al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Development Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Calvin C. Retterer Gertrude S. Kreis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary S. Retterer / Wife 3100 N. Leisure World Blvd., #421, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 X Cremation 3 Removal from State MontgomeryCrematorium,Inc. 16, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Fun A Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Par 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Urinary Tract Infection **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause the property of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the a 9□Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Parkinson's Disease, Alzheimer's Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Failure To Thrive, Comfort Care Olny, Osteoporosis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy this certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö To the Hospital within 24 hours at To the Funeral C Hospital 1 🕇 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 January 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D. 9801 Georgia Avenue, #1-17, Silver Spring, Maryland 20902

State

Registrar

31. Date filed (Month, Day, Year)

JAN 16

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend 19a, perFh, g875, 1/16/08 TT Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Physician 9:30 PM ROJEN SEY MOUR JANUARY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NUMBALLSTOWN BALTIMORE NORTHWEST HOS PITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 130-10-0622 86 Director 10/10/1921 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the them 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐Yes 2 No MD BALTIMORE Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6610 MAROTT DRIVE 21207 USA Completed by Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married ☐Yes 2 Yes, Give 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERK AMERICAN SUGAR COMP. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH ROSEN JENNIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA ROSEN / WIFE Sister 6610 MAROTT DRIVE BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BETH JACOB CONG. 01/15/2008 FINKSBURG, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMIJOPATHY **Physician** CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COROWARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence d) Examiner and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CIRRHOSIS cate has been significant cate has been significant. 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a, Was an certificate has autopsy perform 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 npatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, funeral director, After or Attending

Baltimore, Maryland 21215-0036

death. To the Funeral Director: completely filled in by the hours

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

(Check only one)

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D24325

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) JANUARU

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEOT

PHUSALLSTOWN OLD COURT RUAD HOSPITAL NORTHWEST 5401

State Registrar

within 24 h

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State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 💍 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** Loretta Helen Schlag 14, A^{M} January 2008 3:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Manor Care Health Services -Rossville Rosedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 □ M 2 🛣 F 72 216 32 9062 **Director** Nov. 26, 1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 931 Susquehanna Avenue 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Walter Lamke Mary Anna Mach မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Lynn Williamson (Daughter) 941 Susquehanna Avenue Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 1/18/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 e 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Mary Steel herd 4a. Facility Name (If not institution, give street and number) Genesia Crom well		4b. City, Town, o	r Location of Death	Jan 1	Day Year 7005 4c. County of Dea 3 at 17-	
Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye August 6 1	9. Bir 918 Balt	thplace (State or Foreign ountry) cimore City, Mi
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ш	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	(Month, Day, Ye	
	Director		240-80-5733 58 Yr Usual Residence of Decedent		Jan 17 19	949 NORTH CAROLINA
	and w		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	Mary f sho ed a	2	MARYLAND N/A	BALTIMORE		1XXYes 2 □ No
	the t	Director	MARYLAND N/A 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	with ka or		1449 WALKER AVENUE	21239		U.S.A.
	leath	Funeral	11 Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
10	J within 72 hours after death with the Maryland jaene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	귤	1 1X71X ever Married 2 □ Married 1 1X1X/es 2 □ No		to Hican, etc.)	Black, White, etc.
93	urs a al", o Exam	ğ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 72/74	1 ☐ Yes 2 Ž No Specify:		Specify: BLACK
21215-0036	72 ho natur ica∐	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation	16b	o. Kind of Business/Industry
21	within 7 iene. than "r	adr.	Elementary/Secondary (0-12) College (1-4or 5+)	give kind of work done during most of wo fe. DO NOT use retired)		
21	filed wi Hygien ther th	8	12011 91444	PERVISOR(REC. CLE		McCORMICK CO.
p	be filed Ital Hygi od other event, t	Be (17. Father's Name (First, Middle, Last)		me (First, Middle, Maid E D VALICHN	den Surname)
Maryland	2 should be f n and Mental I ls marked o' raumatic eve	၉	HENRY DAVID SHAW	NANNI	E B VAUGHN	
ar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		,	lailing Address (Street and Number or F		
	r 23	1 3		449 Walker Ave., B		
ore	00		20a. Method of Disposition 20b. Place of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State	isposition (Name of crematory or other place)	Date 20c	c. Location - City or Town, State
altimore,	Pages nent of ant: If its ury or o			Grdn A.M.E. 01-	19-08 BI	URLINGTON, N.C.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensae	22 Name and Address of Facility WILLIAM C BROWN C 1206 W NORTH AVEN		UNERAL HOME P.A.
10	CV-SUI		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	tre Renal G	00 Car	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of		u wi	more 1 yr
	Examiner		Due to (or as a consequence of			
		ē	Sequentially list conditions, if any, leading to immediate			
W	uted Insit	Examiner	rany, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause)			
1	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of	•		
8760,	cate be executed obysician and the burial-transit		d			
89		ğ	U	177		
Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
ă	leath atte	cial	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
Ö	at the de by the a	ysi	9 ☐ Unknown			
σ.	res that signed b		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	quires n sign ald be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w require been sign should b	Completed			24a. Was an	24b. Were autopsy findings available
æ	The lav	Ę			autopsy performed	
Vital			25. Was case referred to medical	26 Place of D	1□ Yes 2 eath (Check only one)	ÎNo 1 □ Yes 2 1 No
⋚		o Be	examiner? 1 Yes 22 No Hospital: 1 Inpatient 2 ER/Outp	Other:	4	re 6 □Other (Specify)
ō	Physer this eral di		27. Manner of Death 28a. Date of Injury 28b. Til	ne of 28c. Injury at	28d. Describe how	77
on	iding P h. After funer	ţi	1/2 Natural 5 □ Pending (Month, Day Year) Inj 2 □ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be 28e, Place of injury - At home, farm	n, street, factory, office	28f. Location (Street	et and Number or Rural Route Number,
Ö	al or after al Direction of the billion ertification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	otate)	
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.			
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
			Waris M Hel	12039	5	1/15708
	1.1		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		, ,
i	Ht 1		Davis M. Hahn 5601 hoch	- Klaver Black	Bult	Mel 21239
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	locate s		

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of I rtificate of			giene Reg. N2 0 0 8	00767
	Physici	an	Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	nth Day Year	3. Time of Death
	/Media	al	YVONNE	SMITH		T		January		10:55 p ^M
	Examir	er	4a. Facility Name (If not institution		ber)		or Location of Death		4c. County of Deal	n
	Funeral		FUTURE CARE-HO 5. Social Security Number		7. Age (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birtl (Month, Day	N/A n 9. Bir	hplace (State or Foreign
	Director		215-84-2830	1 □ M 2 🛣 F	35 Yrs.	Months Days	Hours Min.	(Month, Day JULY 6	1972 MAI	RYLAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	100 Oh. TI					10d. Inside City Limits
	anyla shov	٦	10a. State 10b. County		10c. City, Town or L	ocation				1 X Yes 2 □ No
	28a-f	Director	MARYLAND N/ 10e. Street and Number	'A	BAL'	TIMORE 10f. Zip Code			10g. Citizen of What Co	
	with Sa or		1423 McCULI	OH CADEEA			L217		U.S.A.	outruy:
	s after death with the Marylan , or Items 23a or 28a-f show a tirer must be rediffed at	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S. 13.		Hispanic Origin? (Spe pan, Mexican, Puerto	city Yes or No-		
9	or Ite		1 XX Mever Married 2 ☐ Marr	Armed Ford ied 1 Tes 2 If Yes, Give	2 🔯 No	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)		-
5-0036		d by	3 Widowed 4 Divorced	Year or Da	tes:	1 1 1 1 1 1 2 2 2 3 1 1 1 0	эреспу.		Specify: BI	
15-	c * 30	Completed	15. Decedent (Specify only highes		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Business	Industry
2121	filed within Hygiene. other then "	d L	Elementary/Secondary (0-12)	College (1-	4or 5+)	MPLOYED	, and a second		N/A	
0 2	a filed within Hygiene. other then	a l	17. Father's Name (First, Middle,	Last)	ONE	MPLOIED	18. Mother's Name	(First, Middle,		
an	should be filed nd Mental Hygis marked other umatic event, II	To B	ROBERT L. THO	MAS			LOUVEN	IA S. T	HOMAS	
Maryland	and h		19a. Informant's Name/Relationsi	nip (Type, Print)	19b. Mail	ing Address (Street	t and Number or Rura	l Route Numbe	r, City or Town, State,	Zip Code)
Z	and and mark	9.	Louvenia S. Th	omas/Mothe				-	, Maryland	
ore	ges 1 I of H If Iten or oth		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation	3 □Removal from S	20b. Place of Disponentate	osition (Name of matory or other pla	ace)	ate	20c. Location - City or	Town, State
timore,	tment tent: tent:		`4 □ Donation 5 □ Other (S)	pecify)	METRO CI	REMATORY	01-1		BALTIMORE	
9	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 Is marked eny injury or other traumatic a gnce.	21. Signatur of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOMI 1206 W NORTH AVENUE								
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death. Do not en ch line.	ter the mode of dyi	ing, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. A	egumed 1.	monked 4	Wuney	fyr	1 dome	5.150t and 50ath
	/Medical Examiner		roodking in death)	Due to (o	or as a consequence of):	-0 0 1	, ,	•		
		ē	Sequentially list conditions,	b. Due to (a	r as a honsecuance of):	min				
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		mama					
oʻ	be executed		resulting in death) Last	Due to (o	r as a consequence of):					
8760,	ate hys	lical		d	Herany			-		
9 ×	eath certificate attending phys for use as the	/Mec	IF FEMALE:	23c If was outc	ome of pregnancy				001 Day (1)	a
Вох	attende for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Fetal death 3 [☐Ectopic pregnanc ☐ Other (specify) _	_Б у		23d. Date of de Month	Day Year
P.O.	at the de by the tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov						
	as tha	by Pi	Part II. Other significant condition	ns contributing to dea	ath but not resulting in the u	ınderlying cause gr	ven in Part I.		obacco use contribute to	
of Vital Records,	w require been signature	ted						1 L Y	′es 2□No 3□P	obably 4 Dunknown
ec	as b	Completed						24a. Was autop	sy prior to	topsy findings available completion of cause of
E	Th ate pag							perfor	med? death? 2 No 1 ☐ Yes	2 No
Z.		Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	26. Place of Death			
of		T: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of (Month	patient 2 ☐ ER/Outpatie	nt 3L DOA	4 Thursing Hor		lence 6 Other (Spe	cify)
lon	Attending I r death. ector: After by the funer	tlor	1 ☐Natural 5 ☐ Pending		, Day Year) Injury		ork?]Yes 2.∏No			
Division	Attendii er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place of	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office		28f. Location (S City or Ton	Street and Number or R.	ural Route Number,
Ō	Ital or rs aft rel Dir led in				g, etc. (opeony)					
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier Check only one)	g Physician: To the b Examinar: On the bas and manne	pest of my knowledge, deal sis of examination and/or in er stated.	th occurred at the ti	ime, date and place, a opinion, death occurre	and due to the ded at the time, d	cause(s) and manner as date and place, and due	s stated. s to the cause(s)
	To the To the comp	Z	29b. Signature and title of certifier	. 14			se number		29d. Date signed (Mont	
•			120	VW		- D	31464		1/14/0	l'
	2		30. Name and address of person of AII3 A. H.	- 0	of death (Item 23a) (Type, 21 N. EN F		mil 308	BALTI	mone M	17 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	A.				

Smith (young 1/11/08 10:55mm

	1	For Amend #26 Per Registrar Amend #2 Per		G875 1/ 3875 1/1	16/08 16/08 6/08 J	irimer Ila <i>filica</i> :	te of L	Death	na IVI	ental Hy	giene Reg. No.			768
hysician /Medical		. Decedent's Name (First, Middle, Last MARCELINE RAMONA S								2. Date of De Month JANUAR	Day	2008 ar		e of Death
Examiner	4	a. Facility Name (If not institution, give	street and nu	mber)		,		Location of	Death			County of Dea		
355	_	BALTOWASH. MEDIC Social Security Number 6. Se		TER 7. Age (In yrs.	last hirthday)		N BUI		4 Hrs.	8. Date of Birt	h	NE ARUN		te or Foreign
ineral rector]M 2[X]F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	928 MAI	ountry)	
n vilge virtual	ī	Isual Residence of Decedent		145 50			1							- Cia I i ia-
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		0a. State 10b. County			y, Town or Lo									e City Limits es 2 No
be notified	1	MARYLAND ANNE ARUN Oe. Street and Number	DEL	GLEN	BURNI	_	p Code				10a Citi	izen of What Co		
Di							061			1		ED STAT	-	
liner must	1	106 4TH AVE., S.W.	12. Was Dec	edent Ever in U	.S. 13. \	Nas Dece	dent of H	ispanic Origi	in? (Spe	cify Yes or No		14. Race - Ame	erican Indian	1,
Ē		1 ☐ Never Married 2 ☐ Married	Armed Formal Arme	2 X No	1	i res, spo 1 ∐ Yes		Specify:	rueno i	nican, etc.)		Black, White Specify:	ie, eic.	
þ		3 X Widowed 4 □ Divorced	Year or D	Dates:					_		10) 10		WHITE	
ete		15. Decedent's Edu (Specify only highest grad			16a. Deced (Give	tent's Usi kind of w DO NOT i	ial Occup ork done d ise retired	ation during most (i)	of workir	ng	16D. KI	ind of Business	/Industry	
Completed		Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM			,			OWN	HOME		
Be C		7. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,	Maiden	Surname)		
T B		HARRY W. SHELL						MARGA	RET	V. GRI	FFIN	I		
Ι.		19a. Informant's Name/Relationship (T)				-						or Town, State,		<i>c</i> 1
	_	KAREN SYKES DILL	DAUG					S.W.,		EN BURN		MARYLAN ocation - City or		
	2	0a. Method of Disposition 1 X Byrial 2 ☐ Cremation 3 ☐ I	Removal from	State	Place of Dispo cemetery, crer	natory or	other plac	, 0,	ANUA	RY 9,				
	-	4 □ Donation 5 □ Other (Specify, 21. Signature of Funcial Service Licent	\rightarrow	GL	EN HAV	Name a	nd Addre	ss of Facility	,	80		N BURNI	E, MAI	KILAND
ouce	,	A BUILDING	Ž		KI	RKLE	Y-RUI	DDICK	FUNI	ERAL HO	ME,	P.A. NIE, M	2106	1
	+	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that	caused the deat									Approxi	
er Examiner		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequence of the cons	juence of):									
Physician/Med) and an an an an an an an an an an an an an	F FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown	1 ☐ Live	utcome pf pregni birth 2 Feta prant at time of conown	aldeath 3[⊒Ectopic ⊒ Other (s	oregnancy specify)	/				23d. Date of de Month	elivery Day	Year
2	5	Part II. Other significant conditions	ntributing to	death but not res	sulting in the u	nderlying	cause giv	en in Part I.				use contribute		of death? □Unknown
Completed										24a. Was			autopsy findio	ngs available
E											ormed?	death?		or cause or
Be		25. Was case referred to medical examiner?							of Death	(Check only	one)			
i c	2	1 ☐ Yes 2 No			R/Outpatier			4 🗆 Nui				6 □Other (Sp	ecify)	
2		27. Manner of Death 1 Manual 5 □ Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o Injury	M	28c. Injui Wor	ryat rk? Yes 2 ∐ N		28d. Describe	how inju	ry occurred		
Certification.	200	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plac	e of injury - At h ding, etc. (Speci	ome, farm, str fy)			163 2	-	28f. Location (City or To	Street ar wn, State	nd Number or F e)	Rural Route i	Number,
Cledical		29a. Certifier (Check only one) (Check only one)	iner: On the											ıse(s)
Modica	1	29b. Signature and title of certifier				2	9c. Licens	se number			29d. Da	ate signed (Mor	nth, Day, Yea	ar)
		DY11	MD			2	38	958			1/	7/0	8	
7	-	30. Name and address of person who	ompleted cau	ise of death (Iter	m 23a) (Type,	Print)		9		. 1		1		
		Dateet Sinil	Side	In 208	3 (8a	m	Teph	way	Su	olu	~ 13	anie	MI	21061
State		31. Date filed (Month, Day, Year)	322	Registrar's Sign	ature	8		/						

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State of Maryland / I	Denartment of H	ealth and Mei	ntal Hygiene

				State of Mai	yland / Dep	artme	ent of H	ealth and i	-	giene 008	
			Registrar		Ce	rtitica	ate of L	Jeath	-	Reg. No.	
		, 1	1. Decedent's Name (First, Middle, Last)						Date of Dea Month	ith Day Yea	3. Time of Death
	Physici /Medic		Mary Louise	Snyder						2008	4:55 P M
400	Examin		4a. Facility Name (If not institution, give st	reet and number)	-	4b. Ci	ity, Town, or	Location of Death	า	4c. County of D	eath
170			8004 Colonial	Lane		(Clinto	n		Prince	George's
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday		der 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day		Birthplace (State or Foreign Country)
140	Director		577 42 7148	^{M 2} XX 75	Yrs.	Month	ns Days	Hours Min.	July 18		Washington DC
	p .		Usual Residence of Decedent								
	nylar how	_	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	M Ma	cto	Maryland Prince Geo	rge's	Clin	iton					1 ☐ Yes 2 ☐ No XX
	th the	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of What	Country?
	filed within 72 hours after death with the Maryland Hygiene. Ather then "neturel", or Items 23e or 28e-f ehow ent, it e Medical Examirer must be notilited at		8004 Colonial	Lane		Ì	20735			United St	ates
	dea	Funerai	11. Marital Status	2. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was De	cedent of Hi	spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
9	after or its	교	1 Never Married 2 Married	1 ☐Yes 2 ☐ No					o rican, etc.)		
ဗ္ဗ	ours ref.	by	3 Widowed 4 Divorced	If Yes, Give XX Year or Dates:		T LL T BS	XXNo	Specify:		Specify: W	hite
2	72 hc	tec	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's U	sual Occupa	ation Juring most of wor	ting	16b. Kind of Busine	ss/Industry
2	thin.	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	Killy		
Maryland 21215-0036	gien gien	Completed	10th		Hous	e wi	ife			Own Ho	me
g	e file La Hy oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	Alenta Alenta rked tice	To	Benjamin Taylo	r				Mary	Moran		
ar _y	shoil and N ema	. 1	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Addre	ess (Street a	and Number or Ru	iral Route Numbe	r, City or Town, Stat	e, Zip Code)
	nd 2 alth a 27 is		Charles Snyder (Hu	sband)	800	4 Cc	lonia	1 Lane,	Clinton	MD 20735	
<u>6</u>	s 1 a if He item othe	- 23	20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (f	Vame of	al i	Date	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		1 Burial 2 □ Cremation 3 □ Re Donation 5 □ Other (Specify)	moval from State	Resurrec			jan,δ,	2008	Clinton,	Marvland
三	artm orter inju		21. Signature of Licenses	1 - 11	Kesurrec	2. Name	and Addres	etery is of Facility			6633 01d
ä	Dermi Depa impo any i		11 STATES	M0146	4	1000	ndria	Forry D	d Cline	on, MD 20	705 705
1	1 × 1 ×		23a Part1. Enter the disease, or complic	ations that caused the	ne death. Do not en						Approximate
1	38		shock, or heart failure. List only one	cause on each line							Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Liver	Concer						3 mouths
	Examiner			Due to (or as a	consequence of);						
1		-	Sequentially list conditions, if any, leading to immediate	Due to for as a	eonsaguanea of).						
/	ted nsit	- E	Cause (Disease or injury								
_	xecu and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	_					
760,	be e icien buris	caiE									
387	ires that the death certificate be executed signed by the attending physicien and d be detached for use as the buriat-transit	dic	d.					_			
×	ding se as	Completed by Physician/Medi	IF FEMALE:	c. If yes, outcome of	pregnancy					004 Date of	4-17
Box 68	atten for u	lan	in the past 12 months?	1☐Live birth 2 4☐Pregnant at til	Fetal death 3		pregnancy (specify)			23d. Date of Month	Day Year
o.	the d	ysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	9 Unknown	ne or death 5t	_1 Other	(specify)				
Division of Vital Records, P.O.	that I	윤	Part II. Other significant conditions cont	ributing to death but	not resulting in the	ınderlyin	n cause nive	on in Part I	23e. Did to	bacco use contribut	e to the cause of death?
g,	sign Sign 1 be	ξ	Circhosis	3							Probably 4 Unknown
0	w requir	etec	C.1. 1/03/13							-	700
Şeç	e law hes l	ig I							24a. Was autop	sy prior	autopsy findings available to completion of cause of
<u></u>	: Th	õ							perfor 1 ☐ Yes		/es 2□ No
#	Physician: The la r this certificete hes	Be	25. Was case referred to medical examiner?				14.		ath (Check only or	ne)	
7	hysi this c	မ	1 163 2 140		2 ER/Outpatie			4 🗀 Nursing F	lome 5 Resid	ence 6 Other (S	Specify)
_	ng P	o ::	27. Mayiner of Death 1. SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	of	28c. Injury Work	at ?	28d. Describe h	ow injury occurred	
<u> </u>	eath or: /	cat	2 Accident investigation 3 Suicide 6 Could not be			М	101	fes 2□No			
≥	ter direct	Certification:	4 Homicide	28e. Place of Injury building, etc.	 At home, farm, st (Specify) 	reet, fact	tory, office		28f. Location (S City or Tow	itreet and Number or in, State)	Rural Route Number,
	itel c	S									
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funerel Director: After this certificete hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier Check only 2 Medical Examine	cian: To the best of er: On the basis of e	my knowledge, dea	th occurr	ed at the tim	e, date and place	, and due to the o	ause(s) and manner	r as stated.
	the Print 24	led	one)	and manner state	d.						
	with To	Σ	29b. Signature and title of certifier	, ,			29c. License	number	1	29d. Date signed (M	onth, Day, Year)
			Melula A Hel	Monar,	MD		1)64	234		Juman	4, 2008
	10		30. Name and address of person who con	pleted cause of dea	th (Item 23a) (Type	Print)	A 1 -	. 7	-01	MD 29	
	V		Michaly A. De Man	raco 89	26 Woods	jard	Kd S	cute 201	Clinton	(M) 20	735
100	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	all to					
			with the state of	1075 102,001		48.48					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Stowart Physician January 2008 lavet /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Baltimore UTY HOSPITAL N/A 8. Date of Birth (Month, Day, Year) MAY 12,1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours MARYLAND 1 M 2 F 214 58 7985 56 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State show 1 ☑Yes 2 ☐ No 28a-f sh notified BALTIMORE Director MD. n/a death with the 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ral", or items 23a or Examiner must be r 804 N. LINWOOD AVE 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY College (1-4or 5+) Elementary/Secondary (0-12) POLICE DEPT. 911 OPERATOR 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ever RUTH ROUNDTREE JAMES HOWARD ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BYKES CT. BALTO, CO, MD. 21206 ERIC STEWART Item 27 I (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages
Department of Important: If It
any injury or o GREENMOUNT CREMATORY 1,2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTO, MD. Mature of Funeral Service Licensee B. SCRUGGS FUNERAL HOME Maden 1412 PRESTON ST BALTO, MD. 0 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final adays seps15 **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Drumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Monary huperlandor Hospital or Attending Physician: The law requires that the death certificate be executed physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown is been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2□ No 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death After Injury 5 Pending investigation 1 Tyes ours after death.
neral Director: A 2 Accident 6 Could not be determined 3□ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier

D

State Registrar Medical Doctor

29d. Date signed (Month, Day, Year) 11,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street, Baltimore, MP DIZEZ Mathelier Hansic 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Sheridan, Idolyn Baltimore, Maryland 21215-0036 Physician /Medical Examiner within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician /Medical Examiner

To Be Completed by Funeral Director

_ State	State of Mar	, .u. i u / 1	Certifica Certifica			0	i iy	Reg. No:	000	2 00	-y -y 1
Registrar Decedent's Name (First, Middle, Last)						2	. Date of De	ath	UU	3.1 ille	of Death
Idol	yn Martha	Sheri	dan				Month Janu	ary Day	10,200	58 02	05 M
. Facility Name (If not institution, give si	treet and number)			ity, Town, o	r Location of D	Death			County of De	eath	
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Social Security Number 6. Sex 1□	M 2 □ F 7. Age ((In yrs. last bi 97	Yrs. Month	der 1 Year hs Days	Hours N	Min.	Date of Bir (Month, Da July 9	ıy, Year)		Birthplace (State Country) ew Hamp	_
sual Residence of Decedent		71					иту 9	, 191	LO IN	ew manip	211716
a. State 10b. County		10c. City, Tow								10d. Inside	
Maryland Caroli	ne	Gold	lsboro					40. 0			s 2 👿 No
e. Street and Number 429 Main Street			10f.	Zip Code	636			•	en of What		
	12. Was Decedent Ev	ver in U.S.	13. Was De		636 Hispanic Origin	? (Sneci	fy Yes or No			merican Indian,	
. Marital Status 1 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				lispanic Origin an, Mexican, P	uerto Ri	can, etc.)		Black, W	hite, etc.	
3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	s 2∏ No	Specify:				Specify: V	Vhite	
15. Decedent's Educ (Specify only highest grade		16a	Decedent's U	work done	during most of	f working		16b. Kir	nd of Busine	ss/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)) .	ille. DO NO: Factory	T use retire	d)				Paper		
9th Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle				
	am Murphy						ances				
9a. Informant's Name/Relationship (Typ	pe. Print)	19	b. Mailing Addr	ess (Street	and Number of						
Ora Libby / Daug	ghter		29 Main			ı	Goldsl			land 216	36
a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	20b. Place o	of Disposition (i	Name of		Dat	te	20c. Lo	cation - City	or Town, State	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

PAUL W. Monte w 219 S. Washing

2008

32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9, 2008 2:00 A Claire Kelly Smith January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2√2 F Director Rhode Island 81 June 27, 1926 038-14-4180 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show adleal Examiner must be notified at 1√2 Yes 2 □ No Directo Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death vind Mental Hygiene. Ind Mental Hygiene. Imarked other than "natural", or Items 23s Funeral 3492 Gleneagles Drive 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) traumatic event, the <u>Hospital</u> Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental H John A. Kelly Mary Bergin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau W David S. Smith, Jr./ 5393 George Street, Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 12, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Germantown, Maryland All Souls Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-pir-tory arrest, Approximate ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Subdural Hematoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of physician and the burial-transit that the death certificate be executed Exami Due to (or as a consequence of) Box 68760 Physician/Medical SB signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1□ Yes 2X No 1 ☐ Yes 2□ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify)Hospice 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred ${\tt Pt.tripped}$ & 28c. Injury at Work? Certification: 5 Pending investigation November 17, 2007 1 Natural fell fracturing her right hip & hitting head on the ground

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3492 Gleneagles Dr. Silver Spring, Maryland 20906 Ям Unt 1 ☐ Yes 2X No spital or Attendliours after death.
neral Director: A death. 2 X Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature a nd title of certifier D0064615 W January 10, 2008

State Registrar

31. Date filed (Month, Day, Year)

Genévieve Wroblewski

1355 Piccard Drive, Rockville, Maryland 20850 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Oldic 0	- Warylar		rtificate		ath		Reg. N	.2008	00773
- 10	Physicia	an	1. Decedent's Name								2. Date of De Month	D	ay Year L2, 2008	3. Time of Death 12:24 AMM
	/Medic		Ilya Vas:		alev n, give street and nur	mber)		4b. City. 7	Town, or Loc	ation of Death	Janua	_	c. County of Death	
	Examin	er	Suburban			,				thesda		1	Montgomer	·y
	uneral irector		5. Social Security Nu 073-42-50	503	6. Sex 1 M M 2 □ F	7. Age (In yrs. 70	last birthday, Yrs.	Months		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, Di 07/02	rth ay, Yea 119	9. Birth Cou 37 Bul	place (State or Foreign ntry) garia
rland	at ow		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
Мал	a-f sh iffed a	tor	MD	Monto	jomery	Ro	ckvill	.e						1 ☐ Yes 2 X No
th the	or 28	Director	10e. Street and Num	nber		· ·		10f. Zip	Code			10g. C	Citizen of What Cou	ntry?
ath wi	23a ust b		5832 Eds	on Lane					852-				ited Sta	
1036 ours after de	Department or result and mental ryllene. Important: If then Z1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marrid 3 ☐ Widowed		ied Armed Fo 1 ☐ Yes If Yes, Giv	2⊠ No ⁄e	J.S. 13.		lent of Hispai sify Cuban, M 2⊠No Sµ	nic Origin? (Spo lexican, Puerto pecify:	ecity Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Whi	, etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours all the and Marial Havisians.	e. Ran "natu Medical	Completed	(Speci		t's Education st grade completed) College (1	I-4or 5+)	(Give		Il Occupation k done durin e retired)	l g most of work	ing		Kind of Business/Ir	ndustry unication
24 Ped wi	her th	Ş	47 F-45-4- Non- /	First Middle	1004	5+	Ling	uist	10	Mother's Name	/Eirot Middle	Maide	an Curnama)	
and d be fi	ed of	Be C	17. Father's Name (alev	Lasty					Isvetana			an Sumame)	
aryl shoul	mark	은	19a. Informant's Na		hip (Type. Print)		19b. Mail	ing Address	(Street and	Number or Run	al Route Numi	ber, City	or Town, State, Zi	p Code)
M, Mg	27 Is		Margarety	7 Talev	/Daughter					e Rockv	ille, l	MD 2	0852-	
Baltimore, permit. Pages 1 ar	ant: If item jury or oth		20a. Method of Disp 1 ☐ Burial 2 5 4 ☐ Donation	Cremation	3 □Removal from Specify)	Ci	Place of Disp cemetery, cre hesape	ake Cr	emato	ry	Date Jan 16 2008		Location - City or T	
Balt permit.	Import any In		21. Signature of Fu	neral Service	hun an	MUOS	382 2		d Address of uneral st Ave	& Crema	ation Se er Sprin	ervio	ces Maryland 2	0910-
	-6				complications that conly one cause on e	aused the dea	th. Do not er	nter the mode	e of dying, s	uch as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a. A CANATON TOURS TOURS TOURS TOURS TO SEE AND TOURS TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TO SEE AND TOURS TOURS TOURS TO SEE AND TOURS TOURS TO SEE AND TOURS TO SEE AND TOURS T											
			Due t (or a a consequence on:										· diams	?
Jacob C		Jer	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nditions, mediate	b. Due to	(or as a cons	duence of):	ronic obstructive pulmonory disease						
68760, E. tificate be executed	ig physician and as the burial-transit	Examiner	Cause (Disease or i	njury	с									
50°,	cian a		resulting in death) L	ası	Due to	(or as a conse	quence of):							
024 68760 , ifficate be ex	physic the b	Medical			d									
Box 6	nding use as	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out								23d. Date of deliv	very
P.O. Boat the death	within 24 notes alter death. To the Luneral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		oirth 2 □ Fet nant at time of own		□Ectopic pro □ Other (sp					Month	Day Year
S, F	gned be del	by P	Part II. Other signifi	icant conditi	ons contributing to de	eath but not re	sulting in the	underlying ca	ause given in	Part I.	23e. Did	1		the cause of death?
ord requir	een s	ted	Ischer	nc (ardion	nijojo	ache	2			14	Yes	2 No 3 Pro	obably 4 ∐Unknown
A OI - 12 Vital Records, sician: The law requires t	ate has b	Completed				-					24a. Wa auto per 1∐ Yes	opsy formed?	prior to c	topsy findings available ompletion of cause of
/ita	ertific ector,	Be	25. Was case referrexaminer?	red to medica	Hospital:				1	. Place of Deat	h (Check only	one)		
Or Phys	this or	2	1 ☐ Yes 2 ☐ 27. Manner of Death		28a. Date	· _ /	ER/Outpatie 28b. Time			4 ☐ Nursing Ho	ome 5 Res		6 □Other (Spec	rify)
On light	After fune	tion	1 Natural 2 Accident	5 Pendir investi	ng (Mon	th, Day Year)	Injury	M	8c. Injury at Work? 1 ☐ Yes	2 □No	Edd. Describe	, 11011	jury occurred	
Division Spital or Attending	I Director I Director I Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	Zee. Place	of injury - At h ing, etc. (Spec	nome, farm, s ify)	treet, factory	, office		28f. Location City or To	(Street own, Sta	and Number or Ru ate)	ral Route Number,
Hospita 124 hours	n z4 nour ne Funera pletely fille	ledical C	29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physician: To the Examiner: On the b and man	best of my kn easis of examin ner stated.	nowledge, dea	ath occurred investigation	at the time, o	date and place, on, death occur	and due to th	e cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)
To th	To th comp	Me	29b. Signature and	title of certifie				290	. License nu				Date signed (Month	
			LU	lle	allst	nk	eff	(0 2	3/70)	J	AMMAGI	14,2008
	20		30. Name and address	ess of person	who completed caus	se of death (Ite	m 23a) (Type	Print)	M. Som	110/211	- 2-	رسسوتو دسه	an AM	14, 2008 20814
		to.	31. Date filed (Mont	DAKH.	5/4/ /// D. 32. F	egistrar's Sign	ature UL	WYCO	KINETOL	UN TIKE	DET	HES	DH NIV	20017
	Sta	IG.	(1110111	5 m 5 2 -2	2000	The second	10	MORAN.	j					

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

N = C 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

IN AVENUE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** January 8, 2008 8:15 РМ J. Terauds John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 🕅 M 2□ F Yrs 577-44-5729 72 September 28, 1935 Latvia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Maryland | Montgomery Silver Spring Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code e filed within 72 hours after death with I al Hygiene. I other than "natural", or Items 23a or 2 "natural", or items 23a or 20905 14933 Wellwood Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Government Elementary/Secondary (0-12) College (1-4or 5+) Microwave Engineer Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int; If item 27 Is marked of John Janis Meinhards Terauds Marija Riks မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14933 Wellwood Road, Silver Spring, Maryland 20905 Anita Terauds / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12, 2008 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Fureral Service Licensee M01305 Mydette Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician Atherosclerosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of certificate be executed burial-transit Exami C Difficile Colitis and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy performe 1□ Yes 2X No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 X ER/Outpatient 3 □ DOA ပ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

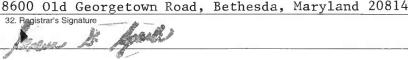
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To th within within to the to the comp

State Registrar 31. Date filed (Month, Day, Year)

William Swann, D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)



DHMH 17 Rev 1/2001

н37188

January 8, 2008

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

ģ

Completed

MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Hygiene.

12 should be filed w th and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examines

ed by the attending physician and detached for use as the bunal-transit g Y signed by the

death certificate be executed

P.O. Box 68760,

Physician/Medical 2 Completed this certificate has ral director, page 2: Be 2

Certification:

Medical

Division or Vital Records, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral funeral State Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy performed?
Yes 21XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

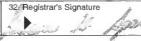
29d. Date signed (Month, Day, Year) January 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

natthew 600 N. WOIFE St Koesia

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

Registrar

D0063682

Beltimore, MO 21287

		Please Type or P					-	_	ble.	
		1- State of State of State of State of State of Registrar Amend 19b, perFH,g876,				lealth and M <i>Death</i>		giene Reg. No. 2	0.0	00777
Division		Decedent's Name (First, Middle, Last)	2,0,00				2. Date of De	ath		3. Time of Death
Physicia /Medic		Sheila Anne Willet					Janua	ry 10, 2		12:25 PM
Examin	er	4a. Facility Name (If not institution, give street and number Holy Cross Hospital	ber)		4b. City, Town, o	r Location of Death Silver S	pring	4c. County Mont	of Death gomery	,
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☑ F	. Age (In yrs. la	es <i>t birthday)</i> Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 22/1945	9. Birthplac Country, CA	e (State or Foreign)
land ow t		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d.	. Inside City Limits
Maryl a-f sho	tor	DC	Was	shingt	on					1 X Yes 2 No
with the 3a or 28 st be not	I Director	10e. Street and Number 5415 Connecticut Ave. NW	#432		10f. Zip Code 20015	_		10g. Citizen of V	What Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 If Yes, Give Year or Dat	ces? 2 🔀 No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto <i>Sp</i> ec <i>ity:</i>	ecify Yes or No Rican, etc.)	Blac	Blace - American Indian, Black, White, etc.	
within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired cems Anal	during most of work d)	ing	16b. Kind of Bu		
uld be filed Mental Hygi Irked other Itic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Archie Leroy Sargent				18. Mother's Name Bernice			ne)	
and 2 sho ealth and I n 27 Is ma ter trauma	1 8	19a Informant's Name/Relationship (Type. Print) Kristen A. Willet/Daughter		933 1	N. Glenda	and Number or Rura le Ave. G	lendal	e, CA 91	206-	
Pages 1 Iment of Hi tant: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	tate ce	metery, crer sapeak	sition (Name of matory or other plac ce Cremate	ory	Jan 14 2008		•	s State
permit Depari Impori any in		Itestud Lolenman	M00382		933 Gist 2		er Sprin	ng, Maryl	and 209	910-
Physician		23a. Part1. Ent or the disease, or complications that caushock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	ch line.	Do not ent		ng, such as cardiac o	or respiratory a	rrest,	A) In O	pproximate Iterval Between Inset and Death
/Medical Examiner		resulting in death) Due to (or	r as a conseque	ence of):			f comments			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d								ay Year
quires that t n signed by uld be detac	by	Part II. Other significant conditions contributing to dea	th but not resul	ting in the ur	nderlying cause giv	en in Part I.		obacco use conti Yes 2™No		cause of death?
: The law rec cate has bee , page 2 shoi	Completed						24a. Was auto perfo 1 Yes	psy ormed2	orior to compl death?	y findings available letion of cause of
sician s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inj	nationt 2 🗆 E	R/Outpatien	nt 3 DOA Oth	26. Place of Death		one) dence 6 □Oth	(0%)	
Attending Phy or death. ector: After thi by the funeral o	Certification: To	27. Manper of Death 1 Naturai 5 Pending (Month) 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined	yat k? Yes 2 □ No	28d. Describe	how injury occurr	red	loute Number,			
Hospital or thours after uneral Dir ely filled in		29a. Certifier (Check only 2	est of my know	rledge, death	h occurred at the tir	me, date and place,	and due to the	cause(s) and ma	nner as state	ed.
To the I within 2. To the I complet	Medical	one) and manne 29b. Signature and title of certifier	er stated.		29c. Licens	e number		29d. Date signed	/	y, Year)
. 1	-	30. Name and address of person who completed cause	of death (Item	23a) (Type,	Print\		2)	1/10/		200
10		CANDACE L. WILSON, 31. Date filed (Month, Day, Year) 32. Reg	m > _ /			GLEN A	3 5	ilver s	TRING	20910
Sta Registr		JAN 1 6 2008	artar a digridit	N. A.	forth					

DHMH 17 Rev 1/2001

			For State Registrar		aryland / De		t of H	ealth a	and M	lental Hy		000	00778
ľ	• Physic		1. Decedent's Name (First, Middle, Last	wood						2. Date of De	ath		
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	HomE	4b. City,	Town, or	Location of	of Death	y		County of Dea	
	Funeral Director		5. Social Security Number 6. Se 023.14.3862		9 (In yrs. last birthda 86 Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8! Date of Bir (Month, Da MAY 30,	th 1921	9. Bi	rthplace (State or Foreign aunity) ENGLAND
	show show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits 1 ☐ Yes 2√∑ No
	or 28a-f	Directo	MD CARROLL 10e. Street and Number		MOUNT AIR	Y 10f. Zip	Code				10g. Citi	izen of What C	
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23s or 28a-f show or other freumatic event, the Medical Examinar must be notified at	by Funeral Director	PLEASANT VIEW NURSING 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	HOME 12. Was Decedent f Amed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 1			spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	USA 14. Race - Am Black, Wh Specify:	
215-0036	ithin 72 ho ie. ian "netur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5	(G.	cedent's Usua ive kind of wo a. DO NOT us	rk done d	lurina mos	t of worki	ng	16b. Ki	ind of Business	
Ind 21	ould be filed within Mental Hygiene. Rerked other than hatic event, Ibe M	Be	12 17. Father's Name (First, Middle, Last)		1.4	ARINE ME	CHANI		er's Name	(First, Middle,		RINA/BOA Sumame)	T YARD
Maryland	2 should I and Men Is marke	은	CLIFFORD WOOD SR. 19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Ma	ailing Address	(Street a		or or Rura	ROM N Route Numbe	er, City o	r Town, State,	Zip Code)
	Pages 1 and 2 nent of Health int: If item 27 iry or other true		LEONARD 5. VOOD 20a. Method of Disposition 1 □ Burial 2 ◯ Cremation 3 ◯		20b. Place of Dis	13 BROOK sposition (Namerematory or o	ne of			ISVILLE Date		754 ocation - City o	r Town, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature → Funeral Service License	1 10 14 4 S	DAYVIEW C	22. Name an FINK FUN	d Addres	s of Facilit	1.14.2 P.A. EN BUR	t/a MARY NIE, MD	LAND	MORTUARY	
V	Physician	0. 1	23a. Part I Enter the disease, or comp shock or heart failure. List only o Immediate Sause (Final disease or condition resulting in d. 3.91)	lications that caused ne cause on each lin	10.	enter the mod		1000			rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	L	Sequentially list conditions	CONGE	STIVE C	ARDIA							Morting
/_	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	REH	AL FAI	LURE							one ronte
68760,	ficate be e physician s the buris	icai		Hyp	BRTENST	en							Years
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3□Ectopic pr 5□ Other (sp						23d. Date of de Month	alivery Day Year
rds, P.	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions co.	- 1 -	ut not resulting in the	underlying c				23e. Did t			to the cause of death? Probably 4 □Unknown
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Vital	/sicien: s certifica director, I	To Be C	25. Was case referred to medical examiner?	fospital:	nt 2 ER/Outpat	ient 3 DC	Othe	-		(Check only one 5 Residue)	one)		
ion of	Attending Phy death. ctor: After thi y the funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time		8c. Injury Work		2	28d. Describe			oury)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	building, etc						City or Tox	wn, State)	Rural Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical	one)	sicien: To the best oner: On the basis of and manner sta	examination and/or ted.	investigation,	, in my op	oinion, dea	th occurre	ed at the time,	date and	place, and du	e to the cause(s)
	with To	N	29b. Signature and title of certifier	Que le		290	License	304	9		Jan Jan	te signed (Mon	2, 2008
	3		29b. Signature and title of certifier B. G. Name and address of person who co	8850, Co	LUMBIA	e, Print) RA	RKW	AY	¥ 30	8; COL	чнв	SiA . A	10-21045.
Eq.	Sta Registr	ite	JAN 1 6 200	37, Registra	r's Signature	narls)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** lllam 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner yview Medical Center (Saltimor If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 217-18-866 Director EM 02-04-1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits la or 28a-f sh t be notified 1 Yes 2 No Director WD DUN DALK BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 31797 301B Dunglow ROAD traumatic event, the Medical Examiner must Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or item any Injury or other traumatic every. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: W W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keal Investor ESTATE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WORTMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DINDALL MD ZIZZZ RD 018 DUNGLOW <u>Jo</u> WOREMAN MARY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Cometere BALTIMORE 4 □ Donation 5 □ Other (Specify) 1-14-2008 22. Name and Address of Facility 2134 Willow Spring 21. Signature of Funeral Service Licenses BALL: MD LUHERN RADLE 5 835 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of): Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last up to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical Se IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🖺 Yes 2 No 3 Probably 4 ₹ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Box 68760, P.O. Records, Division or Vital

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28a-f show

or items 23a

within 24 hours after death. To the Funeral Director; After To the Hospital or Attending completely filled in by the

State Registrar

Medical

Liane 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who complete

29a. Certifier

32. Registrar's Signature

and manner stated.

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Avenue

29d. Date signed (Month, Day, Year)

Mary

Bathmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 700 8 Month **Physician** -rancis M. anaun /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 837 Streaker Road Carroll Svkesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 5, 1944 **Funeral** Months Davs Hours 219-40-3513 63 Yrs. Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Me Acal Examiner must be r 21784 837 Streaker Road USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1960-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No 1960-64 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician Electrical and Mental Hygic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Clark Wall Nellie Flo Simmons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trauonce. Mrs. Linda Gail Wall (Spouse) 837 Streaker Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 1/17/2008 4 □ Donation 5 □ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & Sykesville, MD 21784 & CHAPEL, P.A. (Box 195) (410)-795-1400 MOO 164 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Liver et rehosis disease or condition resulting in death) /Medical Due to (or as a consequence of): 35 **Examiner** years ViRal e petitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the signed by the attending be detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2□ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yo autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 🔲 Inpatient Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Vital Records, P.O. Box 68760,

State

Registrar

29b. Signature and title of certific

ail

29c. License number

Mi O

29d. Date signed (Month, Day, Year)

anday 12 3005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) SUITE.

2008 6

32 Registrar's Signatu

			1 - For Sta		artment of Health and M rtificate of Death		2000 00701
	a. °		1. Decedent's Name (First, Middle, Last)	\	Tillicate of Death	Reg. N 2. Date of Death Month Death	3. Time of Death
	Physici /Medio		Virginia	Wright		Janyar	10 2008 5-50 M
1	Examin	er	4a. Facility Name (Whot institution, give street a	and Rehab	4b. City, Town, or Location of Death	ore	County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) (7) M 1)
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation		10d. Inside City Limits
	the Marylar 28a-f show	Funeral Director	MD N/A	BALTU			1 ☑ Yes 2 ☐ No
	with the	Dire	1628 Chilton		10f. Zip Code		Citizen of What Country? リタイ
	death	nera	11. Marital Status 12. Wa	is Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I		14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e or 28e-f show entry injury or other traumatic event, it a Madical Examinar must be notified at once.	by Fu	1 Never Married 2 Married 1 If Y	Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	ricari, etc.)	Black, White, etc. Specify: BLACK
5-0036	72 hou nature	eted 1	15. Decedent's Education (Specify only highest grade comp	16a, Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
2	within ene.	Completed	Elementary/Secondary (0-12) Col	llege (1-4or 5+)	kind of work done during most of workin DO NOT use retired) 144 & DEL i VSVVY 54		AR KAGISWY
1d 21	ould be filed with Mental Hygiene. Arked other ther atic event, II e.M.	3e Cc	17. Father's Name (First, Middle, Last)	DIVE THE P		(First, Middle, Maide	on Sumame)
ylar	should by nd Menta r marked umatic ev	To Be	John HARRIS			lesten t	****
Maryland	od 2 sho lih and 27 is m		19a. Informant's Name/Relationship (Type, Printed Type). Printed WR19NT		ng Address (Street and Number or Rura 28 ChitTeN ST		
	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr. once.		20a. Method of Disposition 1 ☑Burial 2 ☑ Cremation 3 ☑ Remova	20b. Place of Dispo	osition (Name of Date)	ate 20c. I	Location - City or Town, State
Baltimore,	t. Pag rtment rtant: i		* 4 □ Donation 5 □ Other (Specify)	Foudow	PANK CENTRAY JAN	19 248 Br	4LTO MD
Bal	Departing Department of the police.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility		75 Forward Home
12	*		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not en			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	therosclerchi	Cardiovascula	er dis	Onset and Death
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<u> </u>	ate be executed hysician and the burial-transit	Examiner	that initiated events C.	Due to (or as a consequence of):			
68760,	ate be hysicia ihe bur	icai	d				
9 X	ding pl	/Med	IF FEMALE: 23c. If v	es, outcome of pregnancy			23d. Date of delivery
Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
P.0	hat the od by th detache	Phys	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing		ddarkving cause gwen in Part I	23e Did tobacco	use contribute to the cause of death?
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eco	law requir as been si 2 should l	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
al B	ding Physicien: The lav h. After this certificate has funeral director, page 2		05.44			performed? 1 ☐ Yes 2 Ø N	
f Vital	Physicien: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Tyes 22 No Hospital	l: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	(Check only one)	6 □Other (Specify)
on of	ling Ph		1 XNatural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how inj	ury occurred
Division	Attendi r death. ector: A by the fu	Certification:	Accident investigation Suicide 6 Could not be determined 28e.	. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No reet, factory, office 2		and Number or Rural Route Number,
Ö	itel or irs afte ral Dir			building, etc. (Specify)		City or Town, Sta	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	(Check only 2 Medical Examiner: Or one) an	To the best of my knowledge, deat the basis of examination and/or in d manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier Amaton M Ale	acom MD	29c. License number 1550		ate signed (Month, Day, Year) Anyary 11 2008
	6		30. Name and address of person who complete AMATUM A A	d cause of death (Item 23a) (Type,	Dathin st	3 Ja Balto,	MD 21217
	Sta Registr	-	31. Date filed (Month, Day, Year)	2. Registrar's Signature	alle 1	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00782 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** P. Yeater James 4:30 AM 5008 VI MUCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville 6501 White Rock Rd. 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/12/1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months XXM 2 F Yrs. 235-34-4496 81 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 3 must be r 21784 USA 6501 White Rock Rd. Funeral ıral", or items 2 I Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. MXYes 2 No If Yes, Give Year or DatesKorea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. Specify: White þ 3√Widowed 4 Divorced 'natural' ntal Hygiene. ed other than "natur: event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools Teacher 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be marked c 7 Is marked traumatic e Iva Gertrude Heater Dewey Yeater ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 6501 White Rock Rd., Sykesville, MD 21784 Lael Henry/Daughter Department of Health Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/17/2008 Clarksburg, WV Boring Cemetery 21. Signature of Funeral Service Licensee 228 Hrright Out Erilly Funeral Home & Crematory, P.A. Toll 4 fell 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MEARIT Physician Congestive /Medical Due to (or as a pensequence of) Examiner Years i schemic Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【YNO 24a. Was an autopsy certificate ha performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death.

-uneral Director: A
ely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) MD

DHMH 17 Rev 1/2001

State Registrar 1380

31. Date filed (Month, Day, Year)

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E wers bure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Svite

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00162 State of Maryland / Department of Health and Mental Hygiene Joseph Yaskovic 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ Month Day January 6, 2008 1025 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Joppa 432 Larkspur Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Director 38 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No BALTIMORE or 28a-f show MD notified at once. hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21162 1120 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Yes 9 1 Yes 2 No specify: If Yes. Give Year nt of Health and Mental Hygiene.

f: If item 27 is marked other than "natural", other traumatic event, the Medi-al Examiner. à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 | **Baltimore, MD 21215-0036** WORKER 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other-place) 2 Cremation 3 Removal from State Important: njury or oth -10-08 Other Specify Donation 5 21. Signature of Funeral Service Licensee Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or hear **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, 23d, Date of delivery IF FEMALE: 23b, Was decedent pregnant in the 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Lung disease on Oxygen Completed 24a, Was an this certificate has been Obesity autopsy performed? death? Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital: 1 Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient Inpatient 1 V Yes No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. After within 24 hours after death. Director: To the Funeral

Certification:

Medical

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 V Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 1 V Natural Yes 2 No Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 7, 2008

State

OCME 2006

Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, Yea

29b. Signature and title of certifie

32. Registrar's Signature.

and manner stated

s of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14, **Physician** 2008 9:54 A M Alfred Charles Ziehl, Sr. January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year, Nov. 23, 1 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min 1**X** M 2 □ F 80 217-24-3105 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Parkville Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 4111 21234 USA 8800 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 2/2/46
If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: چ White Year or Dates:12/10/47 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technical Illustrator Bendix permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bul1 John Ziehl Ada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary J. Bory/Daughter 9231 Hines Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Hilltop Service Corp. 1/17/08 |Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) en **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the aftending physician and defached for use as the burial-transit Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u></u> 1 Yes 2 No 3 Probably 4 Unknown neral Director: After this certificate has been silled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2041

State 31. Date filed (Month, Day, Year)
Registrar JAN 16

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ne 6701
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Month **Physician** 02 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death #c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Medical trundel Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 □ M 2 1 F Months NONE Yrs Director aryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State sa or 28a-f show t be notified at 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Numb 10f. Zip Code 180 20716 1mou USA rai", or items 23a Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int; If item 27 is marked other than "natural", or ite ☐ Yes 2 No f Yes, Give 1 Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) / Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other traumatic ev ٩ tranklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 mother Soann Ne 20b. Place of Disposition (Naple of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 4 □ Donation 5 □ Other (Specify) BRUANTOWN 21. Signature of Fufferal Service Licensee 22. Name and Address of Facility MOO no LA. PLATA nd. 23a. Part1. Enter the disease, or complication at a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** Keme resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 burial-transi Exami and Due to (or as a consequence of) Physician/Medical as the attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2√ No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1∐ Yes 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient Certification: To 2 ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0066200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2002/1/6

State Registrar Year)

31. Date filed (Month, Day,

32. Registrar's Signature

			State of Maryland / Department of Health and Me	ental Hygien	2008 00786
			Registrar Certificate of Death	Reg. No.	3. Time of Death
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	Funeral			8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	08 20	08 Maryanol
	nyland how		10a. State 10b. County 10c City, Town or Location		10d. Inside City Limits
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	teme 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
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	the Ha hin 24 t the Fu npletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.		
	To vit	~	29b. Signature and title of certifier HOO 6620		ate signed (Month, Day, Year)
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 0	-08-2008 D 21401
	\	11	131. Date filed (Month, Day, Year) 32. Registrar's Signature	polis, m	1) 21401
	Sta Registr		JAN 1 7 2008		=

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feet.			4a. Facility Name (if not institution, given			41	b. City, Tow		ocation of I	Death		County of Deat rederick	th
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	any	ŀ	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town	or Location	on						10d. Inside City Limits
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212 ald be	Menta mark even	To B	Peter Anderson 19a. Informant's Name/Relationship	Type, Print)	19	b. Mailing	Address	(Street	and Numb	er or Rural Route N	Number, Ci	ity or Town, Sta	ate, Zip Code)
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and S	Health item tran	1.54	20a. Method of Disposition		20b. Place		ition (Name			Date	20c.	Location - City	or Town, State
10r	nt of it: If other		1 Burial 2 X Cremation 3				Crema	tor	v	January 9, 2008	Fre	ederick	, Maryland
it. P	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specific 2 . Signature of Function 1 Service Lice	y: nsee	Beau	22. N	lame and A	ddress	of Facility	Stauffer	Fune	ral Hom	nes, P.A.
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of of	After	٦	27. Manner of Death 1 Natural 5 Ronding	28a. Date of Injury (Month, Day,Year		. Time of	Injury 28		ry at Work' Yes 2 χ		ibe now in	Jury occurred	
ion tend	death ctor: y the	äţį	2 Accident S Pending	ation Fnd 1///ZU		d 4:00					on (Street	and Number of	r Rural Route Number, City
Division tal or Attendin	after Direct	Certification:	3 Suicide 6 X Could n		•	tarm, stre	et, ractory,	orrice t	ounding, etc				kersville, MD
D igi	hours uneral y filled	Š	4 Homicide	ician: To the best of my k	use	looth and	urrad at the	time d	ate and ala				
Division of Vital Records, P.O. Box 68760,	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	ica	(Check only 1 Certifying Physone) 2 Medical Examin	er:On the basis of examin	nowledge, d nation and/o	r investiga	ation, in my	opinior	n, death oc	curred at the time,	date and p	lace, and due t	to the cause(s)
Tot	To t	Medical	29b. Signature and title of certifier	and manner stated.					se number				(Month, Day, Year)

O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD

31. Date filed (*Month, Day, Year*) **31.** Date filed (*Month, Day, Year*) **31.** Date filed (*Month, Day, Year*) **31.** Date filed (*Month, Day, Year*) State Registrar

January 8, 2008

			1- State of Mary	•	artment of He <i>rtificate of D</i>			iene _{eg. No.} 200	8	00788
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	ear	3. Time of Death
	Physicia /Medic		CLYDE WILLIAM BEA	ARD			JANUAR			9:33A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of		
100		纵	FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	FREDERIC:	K If Under 24 Hrs.	8. Date of Birth	FREDE	. Birthpl	ace (State or Foreign
	Funeral Director		1000	73 Yrs.	Months Days	Hours Min.	(Month, Day Sept.10	Year)	Count	land
25.	pu ,		Usual Residence of Decedent	c. City, Town or Lo	ocation				11	Od. Inside City Limits
	faryla shov ed at	or		J. Oity, TOWITOI LC						1 ☐ Yes 2 ☑ No
	the N 28a-1 notifi	rect	Maryland Frederick 10e. Street and Number		Woods 10f. Zip Code	boro	1	0g. Citizen of Who	at Coun	try?
	h with 23a or st be	Funeral Director	10237 Woodsboro Rd.		2	1798		U.	s.A	
	r deat	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	America White, e	
2	s afte	by Fu	1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 195	57-50	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Wh	ite
5	2 hour		15. Decedent's Education	16a. Dece	dent's Usual Occupat	ion		16b. Kind of Busin		
2	thin 7: e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done du DO NOT use retired)					
7	led wii lygien ner th nt, the		12	asst.	. supervis			state o		rnment
2	d be fil intal H ed otl	Be c	17. Father's Name (<i>First, Middle, Last</i>) Clyde T. Beard					Maiden Surname) a Barton		
, l	s 1 and 2 should be filed within 72 hours after death with the Manyland f Health and Mental Hygiene. If Health and Mental Hygiene. A 1s marked other than "natural", or Items 23a or 28a-f show either traumatic event, the Medical Examiner must be notified at	Ը	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street ar				ate, Zip	Code)
Ž	D = 10 = 0		Helga Beard/ wife	10237	7 Woodsbor	o Rd.	Woodsboi	ro, MD 21	798	
υ 5	Pages 1 and the nent of He int: If item iny or oth		20a. Method of Disposition 2 1X Burial 2 □Cremation 3 □Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of ematory or other place		Date	20c. Location - Ci	ty or To	wn, State
	t. Pag tment tant: ijury o		4 □ Donation 5 □ Other (Specify)		11 Cemeter			r. Woods		o, MD
מ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Furteral Service Livensee		2. Name and Address			uneral Ho o, MD 217	_	
	180		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cic E.	ncephalo	gathy				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a co	nsequence of):	,					
	ACC	e	Sequentially list conditions, if any, leading to immediate	insequence of):						
	cuted Id ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ś	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a co	nsequence of):						
	icate t physic s the b	dical	d						-	
3	n certil	Physician/Me	IF FEMALE: 23c. If yes, outcome pf p					23d. Date	of delive	ry
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Helphonth		□Ectopic pregnancy □ Other (specify)			Month	1	Day Year
	nat the	Phy	9 Unknown Part II. Other significant conditions contributing to death but no	ot reculting in the u	inderlying cause giver	in Part I	23e Did to	bacco use contrib	ute to th	ne cause of death?
Ď,	v requires that the death certif been signed by the attending should be detached for use a	d by	Tarrin Still Significant Solidations continuating to deciding at	n roodining in the d	andonying oddoo givor	1117 (417)	1 □ Y	/		ably 4 □Unknown
5	w requir s been si should	Completed					24a. Was a	an 24b. We	ere autor	psy findings available
	The la	ome					autop: perfor 1∐ Yes	med? dea	or to cor ath?]Yes	npletion of cause of 2□ No
Į.	clan: ertifica	Be C	25. Was case referred to medical examiner?			26. Place of Deatl				
5	Physic this c	은	1 Yes 2 12 100 Hospital: 1 24mpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 ☐ Nursing Ho		ence 6 Other		/)
5	Attending Physician: The laver death. rector: After this certificate has by the funeral director, page 2	Certification:	1 Matural 5 Pending (Month, Day Ye		Work?	es 2 No	260. Describe n	ow injury occurred		
2	Atter ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - building, etc. (S	At home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number	or Rura	I Route Number,
5	ital or rs afte ral Dir led in	Cert								
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical	29a. Certifier 1 ☑ Certifying Physician: To the best of m (Check only one) 1 ☑ Medical Examiner: On the basis of exemple one) and manner stated.	amination and/or in						
	To the within To the	Me	29b. Signature and title of certifier	,	29c. License		2	29d. Date signed (Month,	Day, Year)
			Va Most C. Sont,	MD	D00-	52950		January	, 9	7,200 8
	10		30. Name and address of person who completed cause of death							
	15	to		O W. Seve	enth St.	Frederi	ck, MD	21701		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's	de done	B 5					

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

Marlie Bishog 21215-0036

Records, P.O. Box 68760

Division or Vital

State Registrar

6-Hurry 31. Date filed (Month, Day, Year)

JAN 0 4 2008

WARY

COASTAL 32. Registrar's Signature

HOSPILA

P. BOX 1733 SALIS BUNY up 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-00075 Joseph Austin Bi	isco		ease Ty _l St	pe or Print i tate of Maryl	n Bl and	/ Departm	ent of	Health an	e All Co d Menta	pies Are Le Il Hygiene	gible		00000
		1- For State Registrar				Certific	ate of	Death			eg. No.	201	18 UU/9
Physicia Medical Examir			AUSTIN	BRISCOE				b. City, Town, o	Lagation of I	2. Date of Dea Month January 3	Day 3, 2008	Year 3 . County of Dea	3. Time of Death 1400 hrs
		4a. Facility Name (#1 Hickory		on, give street and n	umber)		4	La Plata	r Location of t	Deam		Charles	
Funeral		5. Social Security	Number	6. Sex	7. Ag	e (In yrs. last bir	thday)	If Under 1 Ye				Fore	irthplace (State or ign
Director	ļ	218-52-6		1 X M 2 F		59	Yrs.	Monuts	ys Hours	Min. 04/09	/194	48 0	ountry) MD
any	ı	Usual Residence of 10a. State	10b. County	'		10c. City, Towr		on					10d. Inside City Limits
S land land f show once.	ē	MD	СНАБ	RLES		LAPL	ATA	Trac =: 0			10 c Cit	izen of What Co	1 X Yes 2 No
or 28a-	Director	#1 HTCK		ANE, #310				10f. Zip Code 20646				ITED STA	
ore, MD 21215-0036 8.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at once.	uneral [11. Marital Status 1 X Never Mari		12. Was De						n? (Specify Yes or N Puerto Rican, etc.)	io-	White, etc.	erican Indian, Black,
after de al", or ner mi	by Fu	3 Widowed	4 D	ivorced If Yes, Give Y		7 –1970		Yes 2 X N				Specify:	LACK
hours ? 'nature Exami		15. Decedent's E Elementary/Sec		ecify only highest gr		mprotou)		t's Usual Occup ost of working lif		nd of work done se retired)	16b.	Kind of Business	s/Industry
136 thin 72 ne. than "	Completed	10	condary (U-12	College	(1-4-01		LABO]	RER					OVERNMENT
5-06 lled wi Hygier I other the M		17. Father's Name			·					Name (First, Middle ESTELLE			
21215-0036 and be filed within 7 Mental Hygiene. marked other than	o Be			ART BRISCO)E 	11	9b. Mailing	g Address (Stre		per or Rural Route Nu			ite, Zip Code)
MD : id 2 shot lith and l m 27 is 1	_			NS - DAUGI	ITE					E COURT, S			21144
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic		20a. Method of Di 1 X Burial 2		on 3 Removal	from S	tate crema	atory or ot	sition (Name of o her place)	_ i	Date		Location - City	
Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr		4 Donation	5 Other		_	MARYLAI		FRANS CEM		JAN. 14, 200 THORNTON FU			
Baltin permit. P Departme Importan injury or	0 22	LYDIA C.	THAKNĬ	ON JOHNSON	-	M00583	343	39 LIVING	STON ROA	D, INDIAN HI	AD,	MARYLAND	20640
Physician I I		23a. Part I. Enter failure. List o	the disease, only one caus	or complications that se on each line.									Approximate Interval Between Onset and Death
xaminer		Immediate Cause or condition resul				asphyxia sequence of):	compl	icating a	cute alc	cohol intoxi	catio	on	
	_	Sequentially list of if any, leading to		b	a con	sequence of):	_		_				
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recuted and transit		events resulting i	n death) Las	d	s a con	sequence of):							
oe exec ician ar irial - ti	dical	X UNPENDE	D	AMENDEI #23a	PII	27, 28a-f	, perl	E,g876, 2	/6/08 T	Γ			
D. Box 68760, the death certificate be ex by the attending physician better for use as the burial.	an/Medic	IF FEMALE: 23b. Was deceder		23c. If ye		ome of pregnanc		etal death	Ectopic	pregnancy	2	3d. Date of delive Month	very Day Year
Box 68 e death cert the attendir eed for use a	sicìa	past 12 mont		laka aug	-	at time of death		ther (Specify)					
O. Bc nat the de- ed by the e	Phy			ditions contributing	known g to dea	th but not result	ing in the	underlying caus	e given in Par	rt I. 23e. Did	tobacc	o use contribute	to the cause of death?
ords, P.O w requires that is been signed b	d by	Hyper	tensive	atheroscler	otic	cardiova	scular	disease			es 2		Probably 4 V Unknown
ords aw requinas been 2 should	Completed			· · · · · · · · · · · · · · · · · · ·				·			as an topsy rformed	prior	autopsy findings available to completion of cause of a?
i of Vital Reco ing Physician: The law After this certificate has tuneral director, page 2 s	Com								(B. 45)	1 ✔ Ye		No 1 🗸	
lital Rec sician: The is certificate lirector, page	Be	25. Was case ref examiner?		Hospital:	Inpat	ient 2 ER	Outpatier		Other	Check only one) Nursing Home 5	Resi	dence 6 🗸 O	ther: Scene
n of Vi ding Phys 1. After this funeral di	n: To	1 Yes 27. Manner of De	2 No	28a. Da (Mo			. Time of	· · · _	njury at Work			njury occurred	position
ivision or Attendia after death. Director:	atio	1 Natural 2 Accident		ending 1/3	/200	8 F	nd 1:5	ov pm	Yes 2 X				reathe due to Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law requirement after death. Reral Director: After this certificate has been siftled in by the funeral director, page 2 should b	Certification:	3 Suicide	de	ould not be		Injury - At home sidence	, farm, stre	еет, тастогу, опіс	e bullaing, et	or Town	n, State) Ory	Ln. #310	LaPlata,MD
Hospi 24 hou Funer tely fil		29a. Certifier	Cortifuing	Physician: To the xaminer:On the bas	pest of	my knowledge, o amination and/o	death occu	urred at the time	, date and pla ion, death oc	ace, and due to the c	ause(s)	and manner as:	stated.
To the within To the comple	Medical	29b. Signature a		and manne	er state	d			ense number				(Month, Day, Year)
		Aples	na Br	cassell,	ME)		O.	C.M.E.		Ja	anuary 4, 20	08
(D		30. Name and ac		on who completed o		death (Item 23a al Examiner		Penn Street	, Baltimore	e, MD 21201			
, DB IVA	tate		onth, Day, Yea	ar) 32.	Regist	rar's Signature	-	<i>b</i>					
Regis			JAN 1	1 2008	Class	wa st	B	will					

DHMH 17 Rev 1/2001

Registrar

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		Please	Type or Print State of Mary						_	
		State Registrar		Ce	rtificate of	Death	0.0-1(0.	Reg. No.	2008	00792
Physicia		1. Decedent's Name (First, Middle, La	_				2. Date of De Month	Day		3. Time of Death
/Medic Examin		Juanita Tarver 4a. Facility Name (If not institution, given			4b. City, Town, o	or Location of Death	Januar		2008 County of Deat	1:20 a.m.
LXaiiiii	٠ : چ	21616 Liberty St	reet		Lexing	ton Park			St. Ma	ry's
Funeral	Myss. Y	5. Social Security Number 6. S		n yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di		9. Birt Co	hplace (State or Foreign untry)
Director		248-08-1763 Usual Residence of Decedent	50	Yrs.			6-15-1	1957	Sou	th Carolina
yland sow at		10a. State 10b. County	10	Dc. City, Town or Lo	ocation					10d. Inside City Limits
e Mar la-f st tified	ctor	Maryland St.	Mary's		Lexington	Park				1 ☐ Yes 2 🛣 No
vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Co	untry?
eath v	Funeral	21616 Liberty St	reet 12. Was Decedent Eve	rin IIS 13		653	pacify Vas or N		ted Sta	
fter d r item		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		Was Decedent of H		o Rican, etc.)		Biack, White	
ours a ral", o Exan	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify: B1	ack
"natu	letec	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor	king	16b. Kii	nd of Business/	Industry
withir iene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	0wner		a)		Reau	rty/Clot	hing Store
e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last		Towner		18. Mother's Nan	ne (First, Middle			illing Score
Menta	To E	Edgar Tarver				Almeta D	avis			
12 sho h and r Is m raum		19a. Informant's Name/Relationship (ng Address (Street					•
1 and Healt em 2		Rodney G. Bonner,		20b. Place of Disp			Lexing Date		Park, M cation - City or	
Pages ent of nt: If It		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		Darlingto Memorial	matory or other pla	1	2/2008	Dar 1	instan	S.C.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice			2. Name and Addre					ome, P.A.
8 3 2 6 5					2955 Holl	Lywood Ro	ad, Leo	nardi		20650
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each line.	e death. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sy cars		ncer					
Examiner			Due to (or as a c	onsequence or).						
A 0 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a c	onsequence of):						
executed in and ial-transit	≅xaminer	Cause (Disease or injury that initiated events resulting in death) Last	C	onsequence of:						
be exician a	_		Due to (or as a co	onsequence or).						
certificate be ending physiciarise as the buri	edic	300	d							
	M/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf		⊒Ectopic pregnanc	ev.		2	23d. Date of del	
e dea the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 💢 No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown		Other (specify)				Month	Day Year
The law requires that the death ate has been signed by the atter page 2 should be detached for u	Phy	Part II. Other significant conditions	contributing to death but n	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
quires n sign	d by						1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
aw rec s beer 2 shou	olete						24a. Was		24b. Were au	utopsy findings available
The lav	Completed		-				perf	opsy formed? 2 No	death?	completion of cause of 2 □ No
iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Hoopital		Tou	26. Place of Dea	ath (Check only	one)		
iding Physician: th. After this certifica funeral director, p	: To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4 ☐ Nursing H	lome 5 X Res	_		cify)
nding th. r: Afte e fune	Certification:	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Y		Wo	rk?]Yes 2∐No			,	
r Atte er dea rectol by th	lifice	3 Suicide 6 Could not b 4 Homicide determined			reet, factory, office		28f. Location City or To	(Street an own, State	d Number or Re	ural Route Number,
oital o urs aft eral Di		<u> </u>								
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	29a. Certifier 1/∆ Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	ramination and/or in	th occurred at the ti nvestigation, in my	opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner as d place, and due	s stated. e to the cause(s)
To the Vithin To the Comple	Me	29b. Signature and title of certifier			29c. Licens		- 1		te signed (Mont	
_		10/	M		HO	05575	> (-8-	08
40		30. Name and address of person who					-			
Sta	tę	Jennifer Schmidt, 31. Date filed (Month, Day, Year)	32. egistrar's	Merchant Signature	s Lane,	Suite 205	, Leona	rdto	wn, MD	20650
Registr		JAN 0 8	2008	1 1 1	and of					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, 2008 a January 4:49 р м Kailash Lal Bafna 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth March 14,1930 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2 □ F Months Days Hours n/a 77 India Usual Residence of Decedent 10d. Inside City Limits 10a. State Raj 10c. City, Town or Location 10b. County Jaipor Unknown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code India 64 Vidyut Abhiyanta Colony C-Block Malviya Nagar Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: Indian 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ji Bafna Magan Kanwar Bafna Ratan Lal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4005 Broad Stone St, Frederick, Maryland 21701 USA Jai Nahar, Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 5,2008 Jaipur New Delhi, India 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 USA
Approximate of, Funeral Service Licens M00706 Approximate Interval Between Onset and Death Minutes Asystole Due to (or as a consequence of): Years Coronary Artery Disease Due to (or as a conse | uence of) Aspiration Pneumonitis Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 XNo 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 3□ DOA 2X ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No

/Medical Examiner burial-tran Ó. Box 68760. physician the asn the signed by t d be detach or Vital Records, P. page 2 s has funeral director, death, 24 hours after death Funeral Director: completely filled in by the ō Hospital within 24

Physician

/Medical

Examiner

Director

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Completed

Be

Funeral

Director

show r 28a-f show notified at

ò must be

23a

r than "natural", or Items the Medical Examiner mu

Il Hygiene.

Pages 1 and 2 should be filed went of Health and Mental Hygid ant: If item 27 is marked other?

permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any Injury or other trau

Physician

Injury or other traumatic event,

filed within 72 hours after

Baltimore, Maryland 21215-0036

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) Shipment 21. Signatu 23a. Pal 1. Enter 1. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he 3. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any localing to improve the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 X No 2 27. Manner of Death Certification: XX Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Maryland M54139 January 03, 2008 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Duc T. Le, M.D., 400 West Seventh Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year) JAN 0 4 2008



State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Irving W. Basil Jan. 2008 7:10 a^M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death St. Thomas More Nursing & Rehab Center Prince Georges Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day Year) April 17,1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 230-46-2251 1X M 2□ F 69 Bluemont, VA Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examense must be notified at 1 X Yes 2 □ No Prince Georges Hyattsville Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4922 LaSalle Road 20782 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event, ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Russ Erline Basil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele E. Peterson-Howard / Daughter 42051 Cherish Ct., Aldie, Virginia 20105 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Solon Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 1-12-2008 Middleburg, VA 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLyles Funeral Service P.O. Box 397, Purcellville, Virginia 20134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Arteriosclerotic Cardiovascular Disease Years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage Renal Disease Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension Dementia 24a. Was an page 2 s autopsy performed? Yes 2 1 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 💆 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) ဥ After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural s after death.

I Director: A in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aff To the Funeral Di completely filled in To the Hospital 1 ☑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) wen D01852 Jan. 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Devore, MD, 4203 Queensbury Road, Hyattsville, Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 JAN 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Bohr **Physician** Hdam 2103 Jan 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Poolesville mont ahis 7204 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours Director 217-17-5192 24 JUNE 1983 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County items 23a or 28a-f show ner must be notified at 1XYes 2 ☐ No Director MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 17204 WHITES ROAD 20837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 7 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status i "natural", or itemi ledical Examiner n Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: MEXICAN WHITE þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) STUDENT EDUCATION #e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fi lealth and Mental F ROY RAYMOND BOHR PATRICIA ANDRINA HERNANDEZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 Is any Injury or other traun ROY BOHR / FATHER 17204 WHITES RD., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department MONOCACY CEMETERY 1/5/2008 BEALLSVILLE, 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to o as a consequenc of): Examiner かとしかのか Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to (or as a consequence of) DME Due to (or as a consequence of) burial-Physician/Medical DY Box IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of deli 23b. Was decedent pregnant pic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying of iven in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? 1☐ Yes 2☐ No death? 1 ☐ Yes 2 No Vita Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Injun 1 Natural 5 Pending motor vehicle occident 1 ☐ Yes 2 No I hours after death.

uneral Director: A death. 2X Accident investigation 9 2000 Un K. 6 Could not be determined 3 ☐ Suicide 4 Homicide within 24 hours at To the Funeral C Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 0 3 2008

MICHAEL CETTA, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY ľŏ 2008 10:20 A M SARAH LUCILLE BOWINGS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | 13, | 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 87 213-16-0625 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 ☐ Yes 2 ☐ No Maryland Frederick **Knoxville** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21758 U.S.A. 221 Knoxville Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. 1 ☐ Yes ② If Yes, Give Year or Dates: 1 Never Married 2 Married **ZX**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ath and Mental Hygiene.
27 Is marked other than r traumatic event, the M Clothing Factory Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence E. Moss Alice Stewart ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Rosemont Drive, Knoxville, MD 21758 Health a Linda L. Moss, niece permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery Jan. 12, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service License ²²Keeney and ^{Address} of Bassford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ncomonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed2/ 1□ Yes 2 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: after death.

Director: After this certification in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | → NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0052950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lamonte C. Smith, M.D., 400 West Seventh Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ERO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 14205 NE Oldtown Road 8. Date of Birth (Month, Day, Year) 12-25-3 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months МD 1 □ M 2 □ F Director 218-30-0625 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Cumberland MD Allegany Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 14205 NE Oldtown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xo Maryland 21215-0036 Specify: þ white 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Wholesale Food laborer 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Mary E. Miller Brown Frank J. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland 414 Race Street brother William Brown Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/12/2008 MD Sunset Memorial Park Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 For Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedian Cause (Final disease of condition resulting in death) month **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit Due to (or as a consequence of): physician arts the purial-t P.O. Box 68760 certificate be Physician/Medical as 1 the attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown has been si te 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page this certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA P 1 TYes 2 No 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Ar completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide [Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 0060478 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of CUMBERUMO SETON DR. SUITE AHMAD 904 2 , 2150

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JAN 1 7

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00081 State of Maryland / Department of Health and Mental Hygiene Craig Buffington 2008 1- For State Certificate of Death Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 3, 2008 2150 hrs Craig Bernard Buffington **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Days Hours Months Country) Georgia Director 261-59-1947 1 XM 2 45 01/16/1962 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD PG Upper Marlboro or items 23a or 28a-f sho must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10407 Marlboro Pike 20772 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? USAR If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 ___ No 1 X Yes or Black Specify: or Dates: 81-present Yes 2 X No specify: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. Widowed Divorced ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Manager 4 years Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Billy Poole Annie Buffington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Crystal Buffington - Wife timore, MD 10407 Marlboro Pike; Upper Marlboro, MD 20772 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1/10/2008 | Clinton, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease :xaminer or condition resulting in death) Due to (or as a consequence of): Idiorathic myocardial scarring Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical #PI line a-b. attending physician or use as the burial X UNPENDED perME.g875. 1/25/08 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 V No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 2 Nο 26.Place of Death (Check only one) the Hospital or Attending Physician: director, 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: X Natural Yes 2 Pending 24 hours after death. Director: the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Funeral (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 4, 2008 O.C.M.E.

State 31. Date filed (Month, Day Year)
Registrar JAN 0 9 2008

Laron Locke MD.

OCME

32. Registrar's Signatur

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

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			AMFN) LTFM/I (a, 2) State of Marylar 1 - State Registrar	-	artmeni rtificate				jiene2 (008	00799
	F.		Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physici		MABEL TRULA		BRAI	N		JAN.	Day 9 2	9008	3:30 A ^M
,	/Medi Examir		4a. Facility Name (If not institution, give street and number)				Location of Death			inty of Death	
			GENESIS LA PLATA CENTER		LA	PLA	TA		CH	IARLES	5
	Funeral Director		5. Social Security Number 235-34-8464 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs.	last birthday) 84 Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV • 15	, 1923	9. Birth	place (State or Foreign ntry) IRGINIA
	pu *		Usual Residence of Decedent 10a, State 10b, County 10c, Ci	ty. Town or Lo	cation						10d. Inside City Limits
	arylan	5									XXYes 2 □ No
	28a-1	ect	MD CHARLES L 10e. Street and Number	A PLA	10f. Zip	Code			IOc Citizen	of Whal Cou	ntry?
	with a or	百	NUMBER 1 MAGNOLIA DRIVE			2064	6		•	S. A.	,
	heath	era	11. Marital Status 12. Was Decedent Ever in U	J.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		Race - Ameri	can Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or Items 23a or 28a-1 show event, the Modicel Examiner must be notified at	by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2,5 No If Yes, Give Year or Dates:		lf Yes, spec 1 ☐ Yes 2		Specify:	Rican, etc.)		Black, White, Pcify: WHI	
ŏ	2 hou	ted	15. Decedent's Education		dent's Usua				16b. Kind o	f Business/Ir	dustry
21215-0036	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Cafet	DO NOT us eria	e retired)	uring most of work	arig			
2		Con	9	CAETI	ERIA	WOR	KER		ELEME	ENTAR	SCHOOL
Maryland	should be filed and Mental Hygi marked other imatic event, i	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam				30
yla	should be and Mental marked o umatic eve	은	JOSEPH WISE					'I MARI			
Jar	2 0 0 2		19a. Informant's Name/Relationship (Type, Print)				nd Number or Rui				
	s 1 and 2 if Health Item 27 i		ELIZABETH M. ERWIN/DAUGHT 20a. Method of Disposition 20b.	ER 27.				WALDOR Date		0 2060 on - City or T	
Baltimore,	8°= 5		1 Burial 2 Cremation 3 Removal from State	cemetery, crei	matory`or of	ther place)				
Ë			4 □Donation 5 □ Other (Specify) TR 21. Signature of Fugeral Service Licenses				NS.Jan.				
Bal	permit. Departn Imports eny Inlu		Miland from	5	635 V	VASH	INGTON	AVE. L	A PLA		CES,P.A. 20646
			23a. Part1. Enter the disease, or complication that caused the dea shock, or heart failure. List only one caose on each line.	th. Do not en	er the mode	e of dying				_	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	(NEX)	171	171=		LERI			Kurens
	/Medical Examiner		resulting in death) Due to (or as a consecutive form)	quence of):	Λ		TI FI	10611	Tru	20	J.M.
	LAGITITICS	_	Sequentially list conditions, if any leading to immediate		-, 17	100	14 151	1011210	2101	15	x Won 1 w
1	ed isit	al le	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause (Diseese or injury	quenca oi).					1		
h0_	be executed sician and burial-transit	Examiner	that initiated events c. Due to (or as a consecuting in death) Last Due to	quence of):							
8760,	sician buria	dlcal E									
687	ficate I	ba	U.								
.O. Box	The law requires that the death certificate be executed with hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Tho 9 ☐ Unknown 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pro				23d.	Date of deliv Month	ery Day Year
S, D	res that I	Ď	Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying ca	ause give	n in Part I.	23e. Did to			the cause of death?
P. C.	w requir been si should	eted									
of Vital Record		Completed			-			24a. Was a autop perfor	sy	prior to ex death?	opsy findings available ompletion of cause of 2 No
VII.	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner? Hospital:			Othe	26. Place of Dea				
ot	Phys this al di	ပ္	1 Inpatient 2	ER/Outpatier		A	4 Nursing H	ome 5 ☐ Resid			fy)
	Jing After fune	lo	1 Natural 5 ☐ Pending (Month, Day Year)	Injury	M	8c. Injury Work	al ? ′es 2 □No	Zou. Describe n	ow injury oc	curreu	
Si	or Attending after death. Director: After in by the fune	lca	3 Suicide 6 Could not be 280 Bloom of Injury At h	nome farm st			00 2	28f. Location (S	treet and N	umber or Rur	al Route Number.
Division	affor affor	Certification;	4 Homicide determined building, etc. (Speci	(fy)	, , , ,	, 050		City or Tow	n, State)		
	To the Hospital or Atten within 24 hours after deat To the Funerel Director; completely filled in by the	edical C	29a. Certifier Certifying Physician: To the best of my kn (Check only one) Check only one) Certifying Physician: To the best of my kn (Check only one) Certifying Physician: To the								
	To the within 2 To the Complet	Me	29b. Signature and title of certifier		290	icense	number	- 0	29d. Date si	gned (Month,	Day, Year)
		-	from the low			Ur	201	24	.T A AT	IDDV (2008
	3		30. Name and address of person who completed cause of death (Ite	т 23а) (Туре,	Print)				- O WING	MAL L	
	2		GEORGE WATHEN, M.D. 104 P	EMBRO	KE S	QUA:	RE WALD	ORF, MI	D 206	02	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature	att)			•			
	Regist	त्या	JAN 1 5 2008 1 2000 A	- Parison	- September						

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artmen rtificate	t of Health and <mark>I</mark> e <i>of Death</i>		ene UUO	00800
			Decedent's Name (First, Middle, Last)					2. Date of Deat	n	3. Time of Death
	Physici		Albert L. Beyer					Month	ື່າ 20ປີຢື	9:06 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	-	4b City,	Town, or Location of Death	1	4c. County of Death	1
			Atlantic General H	lospital		Ber'	lin		Worcester	•
	Funeral		Social Security Number 6. Sex		**	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	Year) 9. Birth	place (State or Foreign
	Director		102-24-2505	M 2□ F 78	Yrs.			11/08/1	1929	NY
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Manylia Poho	ō	MD Worcester		Berlin					1 ☐ Yes 2X☐ No
	28e-1	Director	10e. Street and Number		DCTTT	10f. Zip	Code	10	og. Citizen of What Co	untry?
	be filed within 72 hours after deeth with the Maryland at Hygiene. A control of other then "natural", or items 23s or 28s-f show event, I've Medical Examinar must be notified at	ă	23 Breezeway Lane				811		USA	,
	ne 23	Funerai		12. Was Decedent Ever in U.	S. 13. ¹	Was Deced	tent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
0	riter of		1 ☐ Never Married 2 ◯ Married	Armed Forces? 1 ☐ Yes 2/CXNo			offy Cuban, Mexican, Puert	o Rican, etc.)	Black, White	
3	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	100	1 ☐ Yes	2 X No Specify:		Specify: W	nite
0000-c	within 72 hours after ene. then "natural", or ite ha Medical Examina	Completed	15. Decedent's Edu		(Give	kind of wor	al Occupation rk done during most of wor		16b. Kind of Business/	ndustry
V	ithin Ne.	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired)		A	
ч	filed w Hygier ther th	ပ်		4	CPA		10 Mahada Nas	- /Si-A Adiddle A	Accounting	19
	ld be filed ental Hygi ked other Ic event, I	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, A		
2	2 should and Men le marke eumatic	2	Albert Beyer 19a. Informant's Name/Relationship (Ty.	Drine)	10h Maille	Add	(Street and Number or Ru	ve Hickey		in Code)
2	0 m = e	1 15	Edwina Beyer / wi			-	way Lane, Be			ip code/
15	1 and Health em 27 ither ti		20a. Method of Disposition		Place of Dispo			-	20c. Location - City or	Town, State
2	ages nt of :: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State				/2008	Frankford	
	iit. P.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Aicense		pe Hen				ge Funeral	
0	permit. Pages 1 Department of H Important: If ite eny Injury or ot once.		MM Illan	Local			lliam St., B		_	Home
Ė	_		23a. Part1. Enter the disease, or compli	cations that caused the deat						Approximate
I.	Di		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	1	2	1			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	U SI	YYU	>/			1 Now
	Examiner			Cenuech	in Il	funt	Tallure			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	1	701100			
	outed ansit	Examiner	Cause (Disease or injury that initiated events	Carren	Jeu	ed	hyeuse			
ĵ.	en ar en ar irial-t		resulting in death) Last	Due to (or as a conseq	uencelof):	4	10.			
00/0	icate be executed physicien and s the burial-transIt	dical		Kherman	100	ms .	1 SUERCE			
ŏ	certificate be executed nding physicien and use as the burial-transit	Med	IF FEMALE:							
200	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	□Ectopic pr			23d. Date of del Month	very Day Year
5	e death the atter hed for u	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5	Other (sp	ecify)			
Ċ	w requires that the de been signed by the a should be deteched		Part II. Other significant conditions cor	stributing to death but not res	ulting in the u	ndertving c	ause given in Part I	23e. Did tok	pacco use contribute to	the cause of death?
Ď,	signe d be	d b			oning in the c	oony mig o	auto givan iiv aivi	1□Ye		obably 4 Unknown
	y requ	Completed						24a. Wasa	24h Word au	tongy findings available
<u> </u>	hes hes	μ						autops perforr	y prior to o	topsy findings available completion of cause of
	ilcian: The l certificete he rector, page		25 114					1 ☐ Yes 2	2 DNo 1 □ Yes	2000
Ĕ	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ₽	ER/Outpatier		Othor	ath Check only on		-12.3
	Phys rthis aral di	 -	1 Yes 2 VAo	28a. Date of Injury	28b. Time o		28c. Injury at Work?		once 6 □Other (Special own injury occurred	ciry)
5	Alte tune tune	tion	1 V Aatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No			
DIVISION	or Attending Phy ter death. Irector; After thi by the funeral or	E C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he	ome, farm, sti	reet, factory	, office	28f. Location (St City or Town	reet and Number or Ru	ıral Route Number,
5	s after of Director of in by	Certification:		building, etc. (Specif	7/			Jay or rown	., 5.4.0/	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director; completely filled in by the		29a. Certifier 1 Scertifying Physical Exami	sician: To the best of my kno	wladge deat	h pecumod	at the time data and plant in my opinion, death occu-	and due to the au	ate and place, and due	stated to the cause(s)
	the H iin 24 the Fi iplete	Medicai	one)	and manner stated.	orr actio/Or fit					
	To the within 2 To the complet	2	29b. Signature and title of cartifier	4		290	c. License number	, 2	9d. Date signed (Mont	n, Day, Year)
			15/11/544,	(M)			U-35 164		1/02/	08
R	A 10		30. Name an ad ress of person who co	empleted cause of death (Item	п 23а) (Туре,	Print)	6	1.4	1 2100	45
D		1	31. Date filed (Month, Day, Year)	32 Registrar's Signa	Celin (Juxe.	my Cen	as m	e. Mg.	14
	Sta	ate	IAN 0 9 200	N.	ka A	- N .		-		

TON. 09:06

DOD: 11.108

Beyer, Aliocat 102-24-250555#

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Edward William Burch 2008 01 02 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Moon 100 SALBOU If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Vear 1**X** M 2 □ F 142-30-3398 69 10/4/1938 NJ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14 Moonshell Dr. 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Salesman Sports 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest A. Burch Margaret O' Brien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Moonshell Dr., Ocean Pines, MD 21811 Susan H. Burch / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 1/3/2008 Frankford, DE 22. Name and Address of Facility f Funeral Service The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once.

Maryland 2121 Edward

death with the Maryland

attending physician and for use as the burial-tran been signed by the a should be detached t page 2 this certificate funeral After ours after death.
neral Director: A

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner Certification: To Be Completed by

Immediate Cause (Final disease or condition resulting in death)	a. ASCVD Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of deliver Month	very Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to	the cause of death? bbably 4 nknowr
		24a. Was an autopsy performed? 1□ Yes 2 🔊	prior to c death?	topsy findings available ompletion of cause of
25. Was case referred to medical	26. Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Spec	ify)
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe how in		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
	rysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.			

29c. License number

D0063991

100 E. Carrow St. SAUSBURY, MD.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours a

5A11

Medical

State Registrar 29b. Signature and tille of certifier

VARADARAJAN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. M. Signature

ANUPAM

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 0354 A M William Harold Carroll January 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Voar Months 1X M 2□F 219-16-8035 FEB 26. 1925 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County works 10a State ral", or items 23a or 28a-f shov Examiner must be notified at 1 ▼Yes 2 No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 261 West Main Street 21921 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygene.

ant; If lean 27 Is marked other than "natural", or items 23s ant; If lean 27 Is marked other than "natural", or items 13s any or other traumatic event, the Medical Examinar must. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wor1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces? World 1 Myes 2 No World If Yes, Give War II Year or Dates: War II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Baltimore, Maryland 21215-0036 Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Residential Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Joseph Carroll Laura Alma Deibert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 776 Warburton Road, Elkton, MD 21921 JoAnne C. Reeves/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 9. permit. Pages Department of Important: If Its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFARCTION MINUTES MYOCAKOLAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COROWALT ALTENY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duv. to for de a consecuence of sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami ALTERY DISEASE PERIPHENAL Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has b lirector, page 2 s 2 No 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this c 1 Inpatient P After thi 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047711 MO JANUARY 7,2008 2041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite #3 ELATUN MARYLAND DAVID GAR-EL 304-306 North Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

mathan A. Or			cate of Death	Reg. N	
Physic	ian/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da January 4, 20	y Year 2110 hrs
ledical Exam		Jonathan A. Cruz-Vivar 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death
		Doctors Community Hospital	Lanham		Prince George's
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last b		1.6-	M/DD/YYYY) 9. Birthplace (State or Foreign
Director		un-avail 1 ^X M 2 F	1 Yrs. Months Days Hours	October	2,2006 Country) USA
	1	Usual Residence of Decedent 10a State 10b County 10c. City, Tow	un or Location		10d. Inside City Limits
w any		Tod. State			1 Yes 2 No
faryland 28a-f show	ģ	MD Prince Georges New Ca	rrollton	10g.	Citizen of What Country?
e Mar or 28,	Director	6006 89th Ave.	20784	Un:	ited States
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "matural", or items 23a or 28a-f shu rent. the Medical Examiner must be notified at once	ral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origi	n? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
death y	nne	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican,		
after a	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	a. Decedent's Usual Occupation (Give k		Specify: White b. Kind of Business/Industry
hours matur Exam	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)	, , , , , , , , , , , , , , , , , , ,
36 tin 72 than than	ompleted	-00-	none		none
d with	Com	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First, Middle, Mai	den Surname)
21215-0036 and be filed within 72 hours after Mental Hygiene. Mental Hygiene. Americal other than "matural", prevent. the Medical Examiner.	Be	Pedro A. Cruz	19b. Mailing Address (Street and Num	eli Vivar	r City or Town State Zin Code)
		19a. Informant's Name/Relationship (Type, Print) Pedro A. Cruz (father)	6006 89th Ave. Nev		
≥ pala a		20a Method of Disposition 20b. Place	ce of Disposition (Name of cemetery,		Oc. Location - City or Town, State
Ore ges 1 a t of Hu		1 X Burial 2 Cremation 3 Removal from State crem	natory or other place) Jat'l Memo. Park	1/8/08	Laurel, Md
Baltimore, permit. Pages 1 at Department of Het Important. If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Lice	22. Name and Address of Facility		e Lanham Funeral Home
Ba perm Depa Imp		history Dand	9013 Annapolis	Rd. Lanham,	Md. 20706
Physicia		23a Part I. Enter the disease, o complications that caused the death. Do failure, List only one cause on each line.	o not enter the mode of dying, such as co	ardiac or respiratory arrest	
Medica xamine		Immediate Cause (Final disease a. Hypoxic encerhalore	athy with compliations		Death
Xaiiiii		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):			
ecuted					
executian an	Medical	X UNPENDED AMENDED #23a,27, perME, g87	7. 3/5/08 TT		
Box 68760, e death certificate be exemple attending physician	Mec	IF FEMALE: 23b. Was decedent pregnant in the	ncy		23d. Date of delivery Month Day Year
68 certifi nding	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopi 5 Other (Specify)	c pregnancy	inolar 22,
Box 687 death certifice	y Sic	1 Yes 2 No 9 Unknown			and doubted
O at the	를 <u>a</u>		ulting in the underlying cause given in Pa		acco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown
S, P	ed by			24a. Was ar	1 24b. Were autopsy findings available
ord:	plet			autopsy perform	prior to completion of cause of death?
Rec The la	Completed			1 Y Yes 2	No 1 Yes 2 No
Division of Vital Records, P.O. real or Attending Physician: The law requires that the rs after death. To be not	Be (examiner? Hospital: 4 Leastingt 2 1	26.Place of Death R/Outpatient 3 DOA Other		tesidence 6 Other:
Physicer this	Fraid du	1 Yes 2 No 28a Date of Injury 2	28b. Time of Injury 28c. Injury at Wor		ow injury occurred
on on Inding Ith.	ie fun ion	1 X Natural 5 Pending (Month, Day,Year)	1 Yes 2	No	
rision r Atlend ter death. irector:	n by th	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office building, e	tc. 28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City
Dital or urrs aff	filled in by the fune Certification:	4 Homicide determined (Specify)			20
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	etely t	298. Celliel 4 o ve - ne T- the back of my backwood and	e, death occurred at the time, date and p	ace, and due to the cause courred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the within To the	complete	one) 2 Medical Examiner: On the basis of examination and and manner stated.	29c. License numbe		29d. Date signed (Month, Day, Year)
	2	29b. Signature and title of certifier	O.C.M.E.		January 5, 2008
Ŷ		30. Name and address of person who completed cause of death (Item 2			
12		Tasha Greenberg MD. Assistant Medical Examir		ore, MD 21201	
1	State	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature	9		
Reg	jistra	Marie 10 19			
DHMH 17 Rev	1/2001	OCME	ORIGINAL		

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Versie Florence CRIDER January 1, 2008 13:45 p.[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Autumn Assisted Living Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Oct. 19,1910 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 ☐ M 218 F ĬĬĬĬinois Director 357-24-1542 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits in then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 310 Cameo Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: white þ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) machinist food mfg. 6 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Gertie Raines George Stonecipher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other traum once. 1530 Crestview Ave., Hagerstown, Maryland 21740 Leta Stouffer - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hagerstown Crematory 1/3/08 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Furreral Service Li MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Intrechence meta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physicien and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☑ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, s been signer þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? r this certificate had raid director, page 1 Yes 2□ No 1 ☐ Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) AUTUM Hospital: Other: 4 Nursing Home 5 Residence Conter (Specify) ASSIS Livil ို 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: within 24 hours efter death.

To the Funeral Director: After completely filled in by the funer Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide ŏ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Zel Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12.5 D0018019 OK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAG MD 21740 ASAL mill ST 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 03

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2319 Collazo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 X F Months Days Hours 166-36-3470 62 TN Director 6-1945 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must</u> be notified at 1 □Yes 2 No MD Elkton Director Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Price USA 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LPN Nursing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilkerson Wilkerson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hill Rd. Landenberg, 20b. Place of Disposition (Name of cemetery, crematory or other place) Orlando Collazol 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Evans 1-10-2008 Cremator 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Edward L. Collins Funcral Home Inc. PA 19363 Pine St who Oxford. 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ieral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit morbid Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Disknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2□ No 1 ☐ Yes 1∐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 R/Outpatient ဥ 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Physician /Medical Examiner

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			
To the Fun completely	irector: After this certificate has been signed by the attending physici	y the funeral director, page 2 should be detached for use a	
	Dieral D	ly filled ir	

To the HospItal or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

Funeral Director		5. Social Security Number 579-42-0098	6. Sex 1 M 2 ☐ F	7. Age (In yrs. la 74	as <i>t birthday)</i> Yrs.	Months Days	Hours Min.	8. Date of Birti (Month, Day	, Year)	l Co	hplace (State or Foreign untry)
Director		Usual Residence of Decedent						Dec. 1	0, 19	33 Pen	ınsylvania
at		10a. State 10b. Count	y	10c. City	, Town or Loc	ation					10d. Inside City Limits
Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland Ca	rroll			Westmins	ster				1 ☐ Yes 2 🕻 No
or 28 e no	Directo	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Co	untry?
23a ust b		2521 Unionto	wn Rd.				21158			U.S.	
tems ler m	Funeral	11. Marital Status	12. Was Deced	ces?	S. 13. V	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14.	Race - Ame Black, White	
", or l	by F	1 ☐ Never Married 2 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give		ro 1	☐ Yes 2 X No	Specify:		Sp	ecify: Wh	ite
atural cal Ex			ent's Education	1 956-	16a. Deced	ent's Usual Occupa	ation		16b, Kind	of Business/	
in "ng Medic	plet	(Specify only high Elementary/Secondary (0-12)	nest grade completed) College (1-	10554)	(Give I life. D	aind of work done of NOT use retired	during most of world)	king		artmen	·
giene er tha , the	Completed	6	College (1	401 017	mai	ntenance	manager		mair	ntenan	ce
al Hy	Be (17. Father's Name (First, Middle	e, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Su	rname)	
Ment arked atlc e	P_	Max L. Dipp					Eliza	beth Joi	nes		
ls m	П	19a. Informant's Name/Relation				g Address (Street a		ral Route Numbe	er, City or To	own, State, Z	Zip Code)
lealth m 27 her t		Wilma Jean Dip	pery/ wife	OOK DI		Uniontowr	Rd. W	lestmins			
If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	state ce	emetery, cren	atory or other plac	1			ion - City or	
rtmer rtant:		4 □ Donation 5 □ Other (Pip		k Cemete				i nwood	
Depa Impo any ii		21. Signate of Funeral Service	e License	Der		Name and Addres					
		23a. Part1. Enter the disease,	or complications that ca	Jised the death		E. Broad	<u> </u>	or respiratory ar	-	D 21/9	Approximate
100		shock, or heart failure. List Immediate Cause (Final	st only one cause on ea	ch line.					1031,		Interval Between Onset and Death
ysician Medical		disease or condition resulting in death)	a. Due to (Lardi	O H M	onary 1 Hyp	Mrresy				
kaminer			Due to (c	Pula	an a r	· Hu	prtens	ICA			
	Jer	if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequ	ence of):	1 71	Cilchi	, , ,		i	
ransit	Examiner	Cause (Disease or injury that initiated events	C								
ian ai urial-t		resulting in death) Last	Due to (c	r as a consequ	ence of):						
been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical		d								
ding p	Me	IF FEMALE:	23c. If yes, outc	omo of progna	DOV.						
atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	rth 2 □ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d	 Date of deli Month 	ivery Day Year
y the	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unkno		_	other (opeany)					
ned b		Part II. Other significant condi	tions contributing to dea	ath but not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
n sig	eted by							1 🗆 Y	es 2□N	No 3□Pr	obably 4 Nnknown
s bee	olete							24a. Was a			topsy findings available
ate ha	Compl							autop perfor	med?	prior to death? 1 ☐ Yes	completion of cause of 2□ No
ctor, p	O	25. Was case referred to medic	al				26. Place of Dea			12100	2010
his ce I direc	10 B	examiner? 1 Yes 2 No	Hospital: 1 ☐ In	patient 2 🗆 E	ER/Outpatient	3□ DOA Othe	er: 4 🗆 Nursing H	ome 5□Resid	ence 6	Other (Spec	city) Hospice
ofter t	44.	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of (Month)	f Injury n, <i>Day Year)</i>	28b. Time of Injury	28c. Injun Work	y at k?	28d. Describe h	ow injury or	ccurred	
tor: A	cati		tigation				Yes 2□No				
offer of Direction by in by	Certification		mined 286. Place (g, etc. <i>(Specify</i>	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Ru	ıral Route Number,
eral filled		29a. Certifier 1 Certify	ing Physician: To the t	nest of my knov	vledge, death	occurred at the tin	ne date and place	and due to the	rallse/s) an	d manner as	stated
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director.	Medical	(Check only 2 Medica	ai Examiner: On the ba	sis of examinat	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and pla	ace, and due	to the cause(s)
withir	Me	29b. Signature and title of certifi	ier			29c. License	e number		29d. Date si	igned (Monti	h, Day, Year)
		1 anece	Sheh			DO	06478	29	0	1-11	-08
11.		30. Name and address of perso	n who completed cause	of death (Item	23a) (Type, F		- [] 0			1 11	<u> </u>
4		Naveed H. Sh	ah 224	Washing	gton H	eights Me	ed. Ctr.	Westmi	nster	, MD 2	1157

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

			1 - For State Registrar AMEND#12perIN	State of Mar F,1/11/08,BMW,	MbCb C	epartment of F Certificate of			ene _{eg. No.} 200	18 0	08	07
	Physicia	an	1. Decedent's Name (First, Middle, La	•				2. Date of Deat Month		a. T	Time of Dea	
	/Medic	al	Thomas Mitche			4h City Tayra o	ar Location of Dooth	January	1, 2008		45 p	рМ
	Examin	er	4a. Facility Name (If not institution, giv 13003 Valleywood				r Location of Death r Spring		4c. County of	gomery	,	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birtho	lay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (Country)		oreign
	Director		219-01-3183	™ 2□F	88 Yrs	Months Days	Hours Min.	July 3,	1919 V	irgini	.a	
	and w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location				10d. In:	side City L	imits
	Mary -f sho	tor	Maryland	Montgomery		Silver Spr	rina			1 [∐Yes 2₹	∑ No
	or 28s	irec	10e. Street and Number	.ion egomery		10f. Zip Code		10	0g. Citizen of Wha	at Country?		
	23a c	la [13003 Valleywoo	d Drive			20906		USA			
	er dea	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decedent of F If Yes, specify Cub 	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Ind White, etc.	lian,	
0000	ırs aftı Il', or xamil	by F	1 ☐ Never Married	1 Yes 2 No If Yes, Give Year or Dates	Nov. 1941 Feb 1946	1 ☐ Yes 2√☐ No	Specify:		Specify:W	hite		
5	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		15. Decedent's Ed (Specify only highest gra	ducation	16a. De	ecedent's Usual Occup	pation	ina	16b. Kind of Busir	ness/Industry		
V	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	111111111111111111111111111111111111111	live kind of work done le. DO NOT use retire	d)	my				
7	lled w Hygier her th		17. Father's Name (First, Middle, Last	4		Office	Manager 18. Mother's Name	o (First Middle A	Labor	Union		
פ	d be fi	Be c	Eugene E. Dobyn				Erma Lew:	_	naiden Surname)			
Š	should nd Me mark matic	욘	19a. Informant's Name/Relationship (19b. M	ailing Address (Street			City or Town. Sta	ate. Zip Code	,)	
Ž	alth ar		Gladys K. Dobyns	/Wife		13003 Val						906
ກົ	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domoval from State	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	ce) ! _	 	20c. Location - Cit	y or Town, S	tate	
Daltillo	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specif	fy)	Gate of	Heaven Cer		2008 S	ilver Sp	ring.M	larvla	and.
מ	permit Depart Import any In		21. Signature of Funeral Service Licer	nsee		22. Name and Addre Francis J	ss of Facility • Collins	Funeral	Home In	.C.	J	
	40 2 % O		23a Part1 Enter the disease or com	2 Colored the caused the	ne wath Do not	500 Unive	rsity Blvo	d. W., S	ilver Sp		MD 20 oximate	090
	Physician	S 2	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		oner are mode or ay.	ing, oddin do od, dido	or roopiratory arre	551,	Inten	val Betwee et and Dea	en ith
	Physician /Medical		disease or condition resulting in death)	a. Failure T	o Thrive				D	ays		
	Examiner		Sequentially list conditions	Vascular	Insuffic	ciency			M	onths		
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	consequence of):				M	lonths		
	and and II-tran	хап	that initiated events resulting in death) Last	C	consequence of):					Officials		
0/00,	icate be executed physician and s the burial-transit	calE		Congestiv	e Heart	Failure			5	Years	3	
0	tificating phy as the	ledical										
2	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2		3 ☐ Ectopic pregnanc	y		23d. Date of		Vaa	
5	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at tir 9⊡Unknown	me of death	5 Other (specify)			Month	n Day	Yea	1
Ľ	that til ed by detac		Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tob	acco use contribu	ute to the cau	se of deatl	h?
COLCO,	quires n sign uld be	Completed by	Aortic Stenosis,	Cognitive I	mpairmen	nt, Cardio	myopathy,	1 □ Ye	es 2 🔀 No 3	☐ Probably	4 □Unkr	nown
ב כ	aw re	plete	II	m i n				24a. Was ar	n 24b. We	re autopsy fir	ndings ava	ilable
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ובס	clan: ertific ector,	Be (25. Was case referred to medical examiner?	112-1		I au	26. Place of Deat	h (Check only one	e)			
5	Physical this call direct	P_	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ☐ ER/Outpa 28b. Tim	Ment 3 DOA			ence 6 Other			
5	ding th. : After : funer	tion	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Y	/e <i>ar</i>) Inju	ry Woi	rk? Yes 2 □ No	Zod. Describe no	w injury occurred			
2	Atter r deal ector by the	ifica	3 Suicide 6 Could not be determined		- At home, farm	, street, factory, office		28f. Location (Str	reet and Number	or Rural Rou	te Number,	;
5	tal or	Certification:	4 🗆 i loinicide	building, etc. ((Specify)			City or Town	, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		(Check only 2 Medical Exar	nysiclan: To the best of miner: On the basis of e	xamination and/o	eath occurred at the ti or investigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and mann ate and place, and	er as stated. d due to the c	cause(s)	
	o the ithin 2 o the omple	Medical	29b. Signature and title of certifier	and manner state	d.	29c. Licens	se number	29	9d. Date signed (/	Month. Dav. '	Year)	
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	Da		30. Name and address of person who 7350 Van Dusen R	- 00 -7		pe, Print)	M	cie Ama-	Dohreno	MD		
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	1 - For State Registrar	State of Maryland / Dep	artment of Health and rtificate of Death	•	2008	00808
Physician /Medical	D 14 D			2. Date of Death Month Da January 1	y Year 2008	3. Time of Death
Examiner	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deal		. County of Death	0.05,15 111
Funeral Director	200 40 0037		Rising Sun If Under 1 Year If Under 24 Hrs Months Days Hours Min) Coun	.,
yland how	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
the Mar 28s-f •	Maryland Cecil 10e. Street and Number	North E	ast 10f. Zip Code	10a C	tizen of What Coun	1 ☐ Yes 2√∑No
death with the Maryland ms 23a or 28s-f show rates be multified at meral Director	142 Delaware Avenu	ie	21901		ted State	
9 2 3 1	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 TrNo	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Who	etc.
21215-0036 dd within 72 hours aff gjene. then 'natural; or the Madical Exern Completed by F	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) actory Worker		Kind of Business/Ind	,
Maryland 2 nd 2 should be filed and 2 th and Mental Hygie th and Mental Hygie traumatic event, it	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maider Benniger		re ulte ulte
Mary 12 show 1s man 1s man	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Maili	ng Address (Street and Number or R	ural Route Number, City		
Baltimore, I Permit. Pages 1 and Department of Health Inportant: If Item 21 my injury or other 1 page.	Debra Wechter / Da 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other Specify	20b. Place of Disponentery, cre-	Delaware Avenue, sistion (Name of natory or other place) n-Woodlawn 5, 2	Date 20c. L	ocation - City or To 'actoryvi	wn, State Lle,
Baftii permit. P Departm Importar any inju	21. Signature of Foneral Service License	6 2	5, 2 2. Name and Address of Facility Cr 27 South Main Str	ouch Funera		
Physician /Medical	23 Part1. Enter the dise ise, or complic shock, or heart failur List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not en e cause on each line. Due to (or as a consequence of):	er the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
3760, ste be executed exystation and moburial-transit and load Examiner	d	Due to (or as a consequence of):				
I Records, P.O. Box 68 The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other <i>(specify)</i>		23d. Date of delive Month	ry Day Year
S & S & A	Fait ii. Other significant conditions con	ributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to th	e cause of death? ably 4 Unknown
				24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of
Of Vital Physician: T this certificate all director, pa	examiner?	ospital: 1 Inpatient 2 ER/Outpatier		th Check only one Home 5 Residence	6 COthor (Specif	al .
Vision of Attending Physical death. •ctor: After this by the funeral di	27. Manner eath 1 M.tural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury		28d. Describe how inju		7
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification;		28e. Place of Injury · At home, farm, str building, etc. (Specify)		28f. Location (Street as City or Town, State	9)	
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	one)	er: On the bast of my knowledge, dual er: On the basis of examination and/or in and manner stated.	i Secured at the fine, date and plac- vestigation, in my opinion, death occi	a, and due to the cause(surred at the time, date an) and manner as st d place, and due to	ated. the cause(s)
To the within To the comp	29b. Signature and title of centilier		29c. License number 0056	449 1	ite signed (Month, i	Day, Year)
5	30 Name and address of person who con	npleted cause of death (Item 23a) (Type)	High St. Sui	12302 E	TKton M	D21921
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	book			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10:42 PM 2008 <u>Edna Elizabeth Donegan</u> J<u>anuary</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Williamsport <u>Homewood Retirement Center</u> . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🕅 F Yrs 90 219-05-2476 Sep 15 1917 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16505 Virginia Ave. 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Kellv Elsie Plunkerd Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Donegan-daughter in law 1636 Sedgefield Dr Murrells Inlet,SC 29576 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 1-5-2008 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

event, the Medical Examiner

or other traumatic

Department of Health as Important: If item 27 is any injury or other trau

al Hygiene.

ntail is marked Director

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examiner The law requires that the death certificate be executed and Physician/Medical

physician the as signed by need has page this certificate

Completed by

Be

P

Certification:

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

31. Date filed Month

Division or Vital Records, P.O. Box 68760,

or Attending Physician;

Hospital within 24 hours To the Funeral filled in by the funeral

Director: After

25. Was case referred to medical examiner? 1 ☐ Yes

Other: 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

rson who comple cause of death (Item 25%)

29d. Date signed (Month, Day, Year)

State Registrar

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 21,05M John Thomas Eveland, Jr. 2008 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 321 Cecil Street Chesapeake City Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 X M 2 □ F 212-38-1460 69 AUG 19, Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shown any injury or other traumatic event the state. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 321 Cecil Street United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛣 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Completed by 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Clerk Grocerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Eveland, Sr. Kathryn L. Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Eveland/Wife <u>321 Cecil St., Chesapeake City, MD 21915</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 15, 1 Burial 2 □Cremation 3 □Removal from State St. Augustine Chesapeake City, MD 4 Donation 5 Dother (Specify) 2008 Cemetery P.A. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 21. Signa re of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 60 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9∐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗆 No 2 No 1∐ Yes 1 🗆 Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending Injury investigation М 1 ☐ Yes 2 ☐ No 2 [] Accident Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

133 N. Bridge S., ElkTon

			For State Registrar	State o	of Maryla		artment of H		nd Mental Hy	giene Reg. No	2008	00	811
D	e e e e e e e e e e e e e e e e e e e		1. Decedent's Name (First, Middle,	Last)					2. Date of Do Month	eath		3. Time of	f Death
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E	xamin	er	4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, or Freder		Death	4c. County of Death			
E	neral		Frederick Mem 5. Social Security Number	orial Ho		rs. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date of Bi	Frederick Birth 9. Birthplace (State or)			or Foreign
	ector		196-26-1537	1 ⊠ M 2□ F	75	Yrs.	Months Days	Hours	Min. (Month, December	ay, Year) 12.1	1932 Pen	nsylvar	
pua			Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation						
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the N	notifi	Director	10e. Street and Number	LICK		1.1.	10f. Zip Code			10a. Cit	tizen of What Co		
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36 s afte	amin	by Fu	1 X Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 □ Yes If Yes, Gi Year or D			1 ☐ Yes 2 ☑ No	Specify:			Specify: Wh	_	
2 hour	calE	ed k	15. Decedent'	Education		16a. Dece	dent's Usual Occupa	ation		16b. K	b. Kind of Business/Industry		
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Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 71 is marked other than "patural" or items 32a or 28a-f show	even	Be	17. Father's Name (First, Middle, L Ralph G. Frank	*					s Name <i>(First, Middle</i> verda Bowe		len Surname)		
arylan should be nd Mental marked	matic	은	19a. Informant's Name/Relationsh			19h Mailir	n Address (Street a		or Rural Route Numb		ar Town State 7	in Codo\	
≥ ₽ ± %	r other traumatic e		Shirley F. Shi		ister	2903	Roderick	Roa	d, Frederi	ck,	Marylan	d 2 17 04	<u>,</u>
of Hear	rothe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	e) ¦ T	anuary	20c. Lo	ocation - City or	Town, State	
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Baltimore, permit. Pages 1 ar Department of Hea	any injury o		21. Signature of Funeral Service 4:	censee	MO1				d P.A. Fur Street. H			n 21701	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that only one cause on e	caused the de						ELICK, N	Approximat Interval Bet	te
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Physic ruthis of	ial dire	2	1 ☐ Yes No 27. Manper of Death	Hospital: 28a. Date		ER/Outpatien		4 LI Nurs	ing Home 5 ☐ Resi			rify)	
ding h.	funer	tion	1 Natural 5 Pending 2 Accident investiga	(Моп	th, Day Year)	Injury	Work	at ? ′es 2∐No	28d. Describe	how injur	ry occurred		
UIVISION I or Attending after death. Director: Afte	by the	fica	3 Suicide 6 Could no	4 6	of injury - At	home, farm, stre	eet, factory, office	00 20110	28f. Location (Street an	nd Number or Ru	ral Route Num	nber,
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UIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	ely fille	edical (29a. Certifier (Check only Medical E	Physician: To the	e best of my ki	nowledge, death	occurred at the tim	e, date and	place, and due to the	cause(s)) and manner as	stated.	2)
the P	mplet	Medi	one) 29b. Signature and title of certifier	and man	ner stated.				- Cooding at the time,				"/
5 <u>š</u> 5	00	-	29b. Signature and the order ther	and)	29c. License	1397)	,	29d. Dat	te signed (Month	, Day, Year)	
		-	30. Name and address of person w	he completed caus	se of death (It	em 23a) /Type		-11/			110/0)	
	5		Robert L. Kauf	/			,	ot, Fr	ederick, N	Mar.,7	land 217	·01	
XX	Sta		31. Date filed (Month, Day, Year)	\$2. R	Registrar's Sign	nature	The Control		CACL ACK 9 1	шу.	IAIIU 21/	VI.	
Re	egistra	ar	JAN 1 7 20	08	16.1 B	Anna	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month AM /Medical CLAIRE ELIZABETH FLAHERTY JANUARY 2008 2:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MINK HILL ASSISTED LIVING GRASONVILLE **OUEEN ANNE'S** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 🖫 F Director 577-26-3558 83 FEBRUARY 24, 1924 WASHINGTON, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo QUEEN ANNE'S MARYLAND STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 CHESAPEAKE AVENUE death 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify þ Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. 12 ADMINISTRATIVE ASSISTANT GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN ZETTS ANNA CATHERINE STUCKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES FLAHERTY/SON 148 JEAN ROAD, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JANUARY 3 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CHESAPEAKE CREMATION 2008 STEVENSVILLE, MARYLAND al rvice License 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Parti. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, steaty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASTATIC YNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1□ Yes 2 **□** No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 🔲 Yes Other: 1 Inpatient 4 Nursing Home Certification: To 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 ☐ Could not be 3 ☐ Suicide in by Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 2 Medical Examiner; one) and manner stated 29h Signature and te of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar 31. Date filed (Month, Day, Year)

4 JAN 2008

Name and Indicates of person who completed cause of death (Item 23a) (Type, Print)

Que

Registrar's Signature

37064

21666

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** anuary : 10M CATHERINE VTRGTNIA FORD 04 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 M 2 X F 88 Director 216-14-6076 22,1919 MARYLAND APRIL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON BOONSBORO the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be n 8507 MAPLEVILLE ROAD 21713 U.S.A. Funeral ral", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced WHITE item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA WORKER PUBLIC SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED LEE SHIFLER BEULAH VIRGINIA BAKER ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD L. FORD/SON 6221 CLEVELANDTOWN ROAD, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 1/07/2008 BENEVOLA CEMETERY BOONSBORO, MARYLAND 21. Signature o Funeral Se 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ew d disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a conse. P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Rknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an performed? Yes 2 200 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 🗘 1 mpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural
Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29b. Signature and title of fifting

JAN 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

HAGERSTOWN MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 Year 6:45 **Physician** Garrow January James Arthur /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Marv's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1KIM 2 | F 121-38-6251 60 September 8, 1947 New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2KNo Maryland Director St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21895 Pegg Road Apt. 204 20653 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 € Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Disabled Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Joseph Garrow Ida Mae LaFountain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 Tiara Court Elizabeth City, NC 27909 Micheal J. Garrow / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11, January 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2008 22. Name and Address of Facility 21. Signature of Funeral Service License Mattingley-Gardiner Funeral Home, PP.O. Box 270 Leonardtown, MD 20650 uchaeco 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jacob of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 □ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions compibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Browchit15 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3□ DOA Certification: To To the rucspace.

within 24 hours after death.

To the Funeral Director: After thi 28a. Date of Injury 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David M. Federle, M.D. 24035 Three Notch Road Hollywood, MD 20636 egistrar's Signatu 31. Date filed (Month, Day, Year) State JAN 0 8 2008 Registrar

Manuel Antonio Ramirez-Gavarrete Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00155 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar Time of Deaf 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 6, 2008 Year 0102 hrs Manuel Antonio Ramirez-Gavarrete Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Gaithersburg Laytonia Drive at Muncaster Mill Road 9. Birthplace (State or 8. Date of Birth(MM/DD/YYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Honduras
Country) Days Hours Months 7/10/1969 Director none 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 Yes 2 X No Gaithersburg MD Montgomery or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17623 Larchmont Terrace 20877 Honduras 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Honduran White Yes 1 X Yes 2 No specify: If Yes, Give Yea Widowed Divorced "natural", 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene,
Important; If item 27 is marked other than "",
injury or other tranmatic event, the Medical En 72 Auto body Technician Automobile than, 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Elvira Gavarrete Manuel De Jesus Ramirez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0 8 7 7 19a. Informant's Name/Relationship (Type, Print) Jose Luis Ramirez/Brother Larchmont Terrace Gaithersburg, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) X Removal from State 1/17/2008 2 Cremation 1 XBurial Choloma, Honduras Amor Eterno Donation 5 Other Specify PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 re of Funeral Approximate Interval 23a. Part I. En r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death /Medical a Multiple injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical X UNPENDED X #I,25a,27,28a-f, perME,g879, 5/6/08 TT the attending physician ed for use as the burial -The law requires that the death certificate be 23d. Date of delivery Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available Completed ficate has been s page 2 should b 24a. Was an prior to completion of cause of autopsy death? performed? After this certificate has 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 'hin 24 hours after death. the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death subject in altercation and struck Certification: 1 Yes 2 X No Natural Pending by vehicle 1/6/2008 12:51 am the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by or Town, State) Gaithersburg, MD Laytonia Dr. & Municaster, MII 3 Suicide Could not be determined (Specify) local street 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 2. To the F and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 6, 2008 O.C.M.E

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2008

Tasha Greenberg MD

31. Date filed (Month)

Assistant Medical Examiner

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Paul 1 Meredith Hoffman January 10, 2008 2:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10248 Fountain School Rd. Union Bridge Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 12, 1930 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⋈**M 2□F 220-34-2283 77 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemption. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes X☐ No Director Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10248 Fountain School Rd. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel William Hoffman Jessie May Snyder 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Hoffman/son 15055 Grimes Road, Emmitsburg, Md_21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem Gardens Jan.13,2008 Frederick, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of FacilityHartzler Funeral Home P.A. 11802 Liberty Road Libertytown, Md 21762 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) Day /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown arten 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? to balation autopsy perform No No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 24 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HTren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Y momo Incusor Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

08-00005 Mabel B Higdon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physicia		tegistrar 1. Decedent's Name (First, Middle,Last)	00/1///0410-0		- 1	2. Date of Death		3. Time of Death
edical Exami		Mabel B. Higdon				Month I January 1, 2		0427 hrs
2 4 "	•	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Death	
		Ft. Washington Hospital Center		Ft. Washing		1	Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Day		. 8. Date of Birth	(MM/DD/YYYY) 9. Birtl Foreign	n
Director		227-28-8596 1 M 2XF 81	Y r		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jan.27,	1926 Co.	^{ıntry} Virginia
8		Usual Residence of Decedent	0c. City, Town or Loca	ation				10d. Inside City Limits
w any		,	*	ation				1 Yes 2 X No
Maryland 28a-f show d at once.	tor	Maryland Prince George 10e. Street and Number	Accokeek	10f. Zip Code		100	. Citizen of What Cour	itry?
th the Maryland 23a or 28a-f sho notified at once.	Director			2060	١7		U.S.A.	,
ith the 23a o notifi		15603 Farmington Court 11. Marital Status 12. Was Decedent E	ever in II S 13 M	/as Decedent of Hi		pecify Yes or No-		can Indian, Black,
ath wi	Funeral	1 Never Married 2 Married Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, etc.	
ter de		3 v Widowed 4 Divorced If Yes, Give Year	XNo 1	Yes 2 X No	specify:		_{Specify:} Whi	te
urs af tural' amine	d by	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. Decede	ent's Usual Occupa	ation (Give kind of		16b. Kind of Business/I	ndustry
72 ho n "na al Ex	eted	Elementary/Secondary (0-12) College (1-4 or 5-	+) during	most of working life	e. DO NOT use rea	irea)		
036 ithin one. r tha	dmo	12 3	Nu	rse			Dental Of	fice
15-0036 Jied within 72 hours Hygiene. d other than "natu	ပိ	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
2121 Juld be fill Mental I. Marked	B B	Robert B. Brotherton	10b Maili	ing Address (Stre		ge Payne	er, City or Town, State	Zip Code)
D 2 shoul and N 7 is m	욘	19a. Informant's Name/Relationship (Type, Print) Regina H. Smith Daughte:	100				k, Md. 206	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygewin are are are a rear is marked other than "natural", or items 23a or 28a-f she reaumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	20b. Place of Disp	osition (Name of co		Date	20c. Location - City or	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other thingury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State	mD Veter		tory 1	09/08	Chaltanha	m, Maryland
ti. Partmen		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee						in, flat y Larra
Balti permit. Departu Importi			00668	Name and Address Williams 4270 Hawl	tuneral	Home, P. I India	n Head, Md	20640
Physician		23a. Part I. Enter the disease, or complications that caused to	the death. Do not ente	r the mode of dying	, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Madical		failure. List on each line. Immediate Cause (Final disease a. Hypertensive Atl	nerosclerotic Car	diovascular D	isease			Death
₹xaminer		or condition resulting in death) Due to (or as a conse						
	L	Sequentially list conditions, b.						-
	miner	if any, leading to immediate cause. Enter Underlying Cause Co. Due to (or as a conse	quence of):					
	ן ש	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
ecuted and trans	ᄪ	d						
), be exician urial -	ği Gi	UNPENDED AMENDED						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial – transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcom		Fetal death 3	Ectopic pregr	nancy	23d. Date of deliver Month	Day Year
certif	cia	paet 12 months?	=	Other (Specify)		,		
Boy death	Physi	1 Yes 2 No 9 V Unknown g Unknown						
rds, P.O. B requires that the d been signed by the hould be detached		Part II. Other significant conditions contributing to death	but not resulting in th	e underlying cause	e given in Part I.		bacco use contribute to	bably 4 V Unknown
ires the signe	d by	Chronic Obstructive Pulmonary Disease			<u> </u>			utopsy findings available
ords, w requir ts been s	l je					24a. Was autop	sy prior to	completion of cause of
ecol he law ate has	1 =					1 Y Yes	med? death? 2 No 1 ✓ Y	
Vital Rechysician: The lathis certificate la director, page	Be	25. Was case referred to medical		26.Pla	ce of Death (Chec	k only one)		
Vita hysici this o	0	1 Yes 2 No	nt 2 🗹 ER/Outpatio				Residence 6 Othe	er:
ion of tending Pheath. John Stert for: After the funeral	Ë	27. Manner of Death 28a. Date of Inju (Month, Day,Y	ry 28b. Time ear)	of Injury 28c. Ir	njury at Work?	28d. Describe	now injury occurred	
ion ttend leath. :tor:	ati	2 Accident Investigation			Yes 2 No	000 1 11 11	District Alberta F	hural Davida Nicombas, City
ivis or A after Direct	Certification:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, s	treet, factory, office	e building, etc.	or Town, S		tural Route Number, City
D spital hours neral filled	Se	4 Homicide determined (Specify) 29a. Certifier A Certifier Physician: To the best of m			data and place	od due to the excess	co(e) and manner on other	ated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - transi	ical	(Check only one) 2 Medical Examiner: On the basis of examiner	y knowledge, death oc mination and/or investi	ccurred at the time, igation, in my opini	on, death occurred	at the time, date	and place, and due to	the cause(s)
To the To the To the Company	Medical	and manner stated. 29b. Signature and title of certifier			nse number	 	29d. Date signed (M	
	-	QUADTZ -		0.0	C.M.E.		January 1, 2008	3
		30. Name and address of person who completed cause of c	leath (Item 23a)				L	
1RZ		Ana Rubio MD. Assistant Medical Exan	niner 111 Penr	n Street, Baltir	more, MD 212	01		
	State	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	Inarei				
Regi		IAN 0 3 2008 Steel	New SU SO					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Brett Andrew Hudson

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		1- For State Registrar		Cei	rtifica	ate of a	Deatr	7	_		F	Reg. No.			
Physici Medical Exam	an/	Decedent's Name (First, Middl	e,Last) Andrew	Hudson							Date of De Month January 8	Dav	Year 8 ,		3. Time of Death 1653 hrs
**		4a. Facility Name (if not institutio 21665 Cryer Rd	n, give street and	number)		4t	. City, To Avenu		ocation of	Death			c. County of St. Mary		
Funeral		Social Security Number	6. Sex	7. Age (In yrs. I	ast hirth	nday)		r 1 Year	If Under	24Hrs.	8. Date of B	irth(MM	/DD/YYYY)	9. Birth	place (State or
Funeral Director					9	•	Months		Hours	Min.		·	•	Foreign	, ,
D.100101		219-33-2759	1 ^X M 2 F	1	. J 	Yrs.			L		May 1	9,19	988	Cou	ntry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town	or Locatio	n							Т	10d. Inside City Limits
A.	j.		Mary's		Aver										1 Yes 2 X No
faryla 28a-f	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?
ith the Maryland 23a or 28a-f sho notified at once	Dir	21665 Cryer Ro	ad				206	509					USA		
with ns 23 be no	Funeral	11. Marital Status	12. Was D	ecedent Ever in U	l.S.	13. Was	Deceder	nt of Hisp	anic Origi	n? (Spec	cify Yes or N	0-	14. Race	Americ	an Indian, Black,
death r iter nust	nue	1 X Never Married 2 M	arried Armed	Forces?						Риепо кі	ican, etc.)		White		
after al", o	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: Specify:									Whi	te				
ours a atura	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busing									iness/Ir	ndustry				
6 72 h m "n ral E	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)] `	Juling Inc	St Of WOI	King inc. i	30 110 1	300 100100	۵,	1			
orthin vithin ene.	ш	10			Nev	ver W	lorke						/A		
5-0 lled v Hygi Tothe		17. Father's Name (First, Middle,	, Last)					18	B.Mother's	s Name (F	First, Middle	, Maider	n Surname)		
21215-0036 uld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be	Harold David									rie W				
2 2 2 A D D D D D D D D D D D D D D D D	မ	19a. Informant's Name/Relations			4	_		,			ral Route No		-		
MD nd 2 sho alth and m 27 is aumati		<u>Harold David Hu</u>	<u>dson / F</u>	ather		L665 of Disposit					ue, Ma				
slar Slar of Hee If ite		20a. Method of Disposition 1 X Burial 2 Cremation	a 3 Remova			ory or other nts Ep			etery,	Janu	Date Iary	20c.	Location -	City or	Town, State
Page Page nent o		4 Donation 5 Other S		AII	. Saı	nts E _l Ceme		pal		12,	2008	Av	enue,	Mary]	land
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleatht and Mental Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-fahe injury or other traumatic event, the M-dical Examiner must be notified at once		21. Signature of Funeral Service	Licensee	1	-	22. Na	me and	Address	of Facility	Matti	ngley-				l Home, P.A.
E P P E		Whichael	/ ·	rame							n, Mar			L.,	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		t caused the death	n. Do no	t enter the	e mode o	of dying, s	uch as ca	ardiac or r	espiratory a	rrest, sh	ock, or hea	ırt	Approximate Interval Between Onset and
Medical	Contact shotgun wound of chest									Death					
taminer		or condition resulting in death)		s a consequence of	of):										
		Sequentially list conditions,	b												
	ine	if any, leading to immediate cause. Enter Underlying Cause		s a consequence o	of):										
ted	Examiner	(Disease or injury that initiated events resulting in death) Last	•	s a consequence of	of):						-				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after during Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	dAMENDE	D							_				
50, te be sysici	led.	IF FEMALE:		s, outcome of preg	nancy							23	3d. Date of	delivery	
8760, tificate be ng physici as the buri	١	23b. Was decedent pregnant in the	he 1 Liv	e birth	2		al death	3	Ectopic	pregnanc	су		Month	•	ay Year
OX 68 eath cert attendir	icia	past 12 months?	4 Pre	gnant at time of d	eath 5		er (Spec	cify)				120001			
Box 68 e death certi	Physicia	1 Yes 2 No 9 Un	known g Un	known											
bat the cetach.	by P	Part II. Other significant condit	tions contributin	g to death but not	resulting	g in the ur	nderlying	cause gi	ven in Pa	rt I.					the cause of death?
ires th	d b	<u> </u>									1Y	es 2	✓ No 3		
ords, P w requires to s been sign should be o	lete										24a. Wa	s an opsy			topsy findings available completion of cause of
SCO re faw re has ge 2 s	Completed						-					formed?	' '	eath? ✔ Ye	
ital Recician: The scertificate rector, page		25. Was case referred to medica	at I					26.Place	of Death (Check or				V 10	.5
Vita ysicial his cer directe	Be	examiner?	Hospital:	Inpatient 2	ER/O	utpatient	p		Other ₄		Home 5	Resid	tence 6 V	Other	: Scene
of V g Phy ier th	<u>1</u> :	1 Yes 2 No 27. Manner of Death	28a. Da			Time of In		28c. Injury	at Work	? 2	28d. Describ			ed	
OD C nding th. r: Af	io.	1 Natural 5 Pen		ate of Injury onth, Day, Year)		JND:		1 Y	es 2 🗸	No S	Subject sh	ot sel	f		
isic Atte Pr dea recto by th	icat		28e P	, 2008 lace of Injury - At h		hrs nm. stree	t, factory	, office bu	uilding, etc	c. 2	28f. Location	(Street	and Number	er or Ru	ral Route Number, City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. Reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	3 V Suicide 6 Could not be determined Specify) Single Family 286. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of or Town, State) 28f. Location (Street and Number of Or Town, State) 28f. Location (Street and Number of													
lospii Fospii Houn Tuner												ed			
To the H. within 24 To the Fr	lica	(Check only one) (Check only									e cause(s)				
To To Com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon.													
	O.C.M.E. January 9, 2008														
	30, Name and address of person who completed cause of death (Item 23a)														
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
		9		Registrar's Signar			.,	, 1							
	tate	31. Dajan (1100 D2008)	The same	giorna o Oigila	1	£ 1									

State Registrar

DHMH 17 Rev 1/2001

PATBINDER

31. Date filed (Month, Day, Year)

JAN 1 0 2008



30. Name and address of person who completed cause, of death (Item 23a) (Type, Print)

32. Registrar's Signature

LiLL

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			1_ For Amend #2	State of I Ob per FH (Marylan 01-11-2	d / Depa 2008- C	artment of H	lealth and	•	0.0	108	nns	R 2 N
		SV.	Registrar 1. Decedent's Name (First, Middle			Ce	lilicate of t	Jealli	2. Date of De	Reg. No.	100	3. Time o	f Death
	Physici	an							Month	Day	Year		NA.
	/Medic		4a. Facility Name (If not institution			ISER	4b. City, Town, or	Location of Dea		y 1, 20	ty of Death	3:25	A
	Examin	er	Frederick Men				Freder				deric	<	
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr		th	9. Birthi	place (State	or Foreign
ı	Director		560-96-1910	1⊠M 2□F	55	Yrs.	Months Days	Hours Mir	Aug. 2	2, 1952	Cal	ntry) iforní	.a
	p.		Usual Residence of Decedent		140- 07	. Tour and a					1.	10d. Inside C	Mar Limetan
	arylaı show d at	_	10a. State 10b. County		Toe. City	y, Town or Lo							aty Limits 2 □ No
	he M 18a-f otifie	Director		lerick		Fre	derick		Т	10g. Citizen o	Mhat Cou		
	with t		10e. Street and Number	1			10f. Zip Code	1700					
	eath is 23	eral	26 North Pend	12. Was Decede		S 13		1703	Specify Yes or No		ted S		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natura", or Items 23a or 28a-f show evert, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	Armed Force	es?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2점 No	Specify:	erto Rican, etc.)	Spec	ack, White,	etc.	
ş	2 hou atura cal E	be le	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/In	ndustry	
215	filed within 72 Hygiene. other than "nai oth, the Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	(Give life.	kind of work done on NOT use retired	during most of w d)	orking				
21	d with	E O	12			Netw	ork Engin					rnment	
2	be filed tal Hygid d other event, II	Be (17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Middle	, Maiden Surna	ame)		
<u>ya</u>	2 should be filed and Mental Hygi Is marked other raumatic event, II	မ	George Richard						M. Faus		_		
Maryland 21215-0036	2sh nand raum		19a. Informant's Name/Relations				ng Address (Street						.00
	1 and Health em 27 ther to		Robin E.J. Hei 20a. Method of Disposition	ser / Wite	20h P		. Pendlet		n Pate 3, 20				03
Baltimore,	of of		1 ☐ Burial 2 【ACremation		ate	•	osition (Name of matory or other place	″் ¦ .Iar	mary				. 1
	it. Partitude		4 ☐ Donation 5 ☐ Other (S		Sta		Cremator			Frederi			
Ba	permit. Pag Department Important: I any Injury o			31.4			2. Name and Addre						
			23a. Part1. Enter the disease, or	complications that cau	sed the death						, mar,	Approxima Interval Be	ite
	Physician		shock, or heart failure. List Immediate Cause (Final			ENOCE	ARCINEM	A ME	TASTAT	7C		Onset and	Death
1	/Medical		disease or condition resulting in death)	- Car	as a consequ			1					
8	Examiner		Sequentially list conditions,	h. ======									
	₽ #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	derice of):							
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98760	icate be executed physician and s the burial-transit	dical		d									
O. Box (The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outco 1 □Live birtl 4 □ Pregnan 9 □ Unknow	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of delivery Month Day Year					
Vital Records, P.O.	res that the de signed by the a be detached f		Part II. Other significant condition	ons contributing to deat	th but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of	death?
dS S	luires n sign ld be	Completed by	POLMONDRY E	EMBULISM INSUMONI TRUCTION	ACUT	E			1 🗆	Yes 20 No	3 ☐ Pro	bably 4]Unknown
ပ ္ပ	w require s been signature should b	lete	ASPIRATION	INEUMONI.	4				24a. Was	an 24t	. Were aut	opsy findings	available
2	Physician: The lav this certificate has al director, page 2.3	mc	BOWER ESS	TRICTION	SMA	ZL ROL	EC.			ormed?	death?	ompletion of a 2 □ No	cause of
<u>e</u>	an: tifical tor, p	Be C	25. Was case referred to medica		, - ,,	/3		26. Place of D	ath (Check only	2 No	1 🗆 Tes	2010	
	ysiclis cer	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1) Inp	atient 2	ER/Outpatie	nt 3 DOA Oth	or:	Home 5□Res		ther (Speci	ify)	
0	ng Ph ter th neral		27. Manner of Death 1/K Natural 5 ☐ Pendin	28a. Date of	Injury Day Year)	28b. Time o	f 28c. Injur Wor			how injury occ			
Š	ttending P death. tor; After t the funera	atio	2 ☐ Accident investi	gation		,,		Yes 2 ☐ No					
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place of building	f injury - At ho , etc. <i>(Specif</i>	ome, farm, st <i>y)</i>	reet, factory, office		28f. Location (City or To	Street and Nur wn, State)	nber or Rui	ral Route Nui	mber,
	pital ours al		29a. Certifier 1 Certifyir	ng Physician: To the be	ant of my kno	uulodao doa	h accurred at the ti	me date and ple	and due to the	nouse(s) and	mannores	nt nt n d	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		Examiner: On the bas and manne	is of examina r stated.	ition and/or in	ivestigation, in my	opinion, death or	ccurred at the time	, date and plac	e, and due	to the cause	(s)
	of the somple	Me	29b. Signature and title of certifie	1000			29c. Licens	e number		29d. Date sign	ned (Month	, Day, Year)	
)	. A		> Frond	Carres 5	MA		D3	11761		1/1,	168		
3	Ot In	:	30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,	Print)	T. FR	ENSFICK	= MD	217	701	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 4	2008 32. Peg	gistrar's Signa	ture	neveli						
	negisti	aı	JAN U 4	2 2000	ال ماناسان	- 17							

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			For State Registrar	State of Ma	iryianu / i		ificate of E		iu ivienta		ene eg. No.2 0	8 (008	321
Г	Physicia	an	Decedent's Name (First, Middle, La Norman K. Haywo						Mor	e of Death nth luary	Day	Year Q	3. Time of 1:00	Death A M
y 240	/Medic Examin	- 4	4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of D		luary	4c. County o		1.00	
1	Examin	CI	WMHS Memorial Ca				Cumber	land				egan	У	
to a	Funeral Director		217-07-3592	Sex 7. Age 1 ☑ M 2 ☐ F 97	(In yrs. last bi	rthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date (Mo	e of Birth onth, Day,]_0/1_0	Year)	9. Birthp Coun	lace (State o	r Foreign
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loca	ation					1	0d. Inside Ci	ty Limits
	Maryl f sho	to	W Mineral	L	Keyse	er							1 X Yes	2 □ No
	with the	Funeral Director	10e. Street and Number 445 St. Cloud St	ceet			10f. Zip Code 26726			10	10g. Citizen of What Country?			
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 23a-f show ent, the Medical Eximiner must be notified at		11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1X Yes 2 N If Yes, Give Year or Dat	0		l as Decedent of His Yes, specify Cubar □ Yes 🏚 📆 No	spanic Origin n, Mexican, F Specify:	n? (Specify Ye Puerto Rican, e	pecify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white		
Ö	hours tural	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's B			16a. Decedent's Usual Occupation				16b. Kind of				
215	hin 72 e. an "na Medic	plet	(Specify only highest gas Elementary/Secondary (0-12)	rade completed) _College (1-4or 5		(Give k life. D	ind of work done di O NOT use retired)	uring most o	of working	, ob. (and of business) musely				
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and	8 0 m e	Be	17. Father's Name (First, Middle, Las Thomas Haywood, S				}		inda Tro		faiden Surname	,		
Maryland 21215-0036	2 shc and is m	으	19a. Informant's Name/Relationship Mindy Ray/daughte	(Type. Print)			Address (Street a	nd Number	or Rural Route	Number,			Code)	
	s 1 and if Health item 27 other to		20a. Method of Disposition		20b. Place o	of Disposi	ition (Name of atory or other place	9)	Date	2	20c. Location - C	City or To	own, State	
E	Pages nent of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		1		Memorial	1	1/12/0	8 F	Keyser,	WV		
Baltimore,	permit. Pag Department Important: II any Injury o		21. Signature of Funeral Service Lice	noh		Ma D	Name and Address I KWOOD Fi O. Box 9	s of Facility Ineral	Home,	Inc.	5726			
F			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	me death. Do	not ente	r the mode of dying	, such as ca	ardiac or respir	ratory arre	est,		Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	_a Closed H									Onset and I	Jeath
	/Medical Examiner		resulting in death)		consequence							1		
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Sp	outed ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	C.							/	\cap		
Ö,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):			/	//	0 /	\mathcal{I}		
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Box	ath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf pregnancy 1						23d: Date or Month				Year
0.	hat the de d by the detached		9 ☐ Unknown Part II. Other significant conditions	contributing to death bu	ut not resulting	in the un	derlying cause give	n in Part I.	23	e. Did tob	pacco use contri	bute to t	he cause of c	ieath?
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	Physical this call dire	ပ္	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		utpatient Time of	3 DOA Othe	4 LI Nurs			ence 6 Othe		fy)	
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Division or	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitely filled in by the funeral director, tely filled in by the funeral director.	Certification:	3 Suicide 6 Could not determined	28e. Place of inju- building, etc	ry - At home, f c. (Specify)	arm, stre	et, factory, office		28f. Loc Cit	ation (Str	reet and Number, State) 445	St	726	Stree
	e Hospital or Atte 124 hours after de le Funeral Direct letely filled in by th	Medical C	29a. Certifier 1 Certifying F (Check on 2 Medical Ex	nysicien: To the best of amlner: On the basis of and manner sta	of my knowledg examination a ited.	ge, death and/or inv	occurred at the time estigation, in my op	ne, date and pinion, death	place, and due n occurred at the	e to the ca	ause(s) and mar ate and place, a	nner as s	stated. o the cause(s)
	To the Hosp within 24 ho To the Fund completely f	Me	29b. Signature and title of tertifier		29c. License			29	9d. Date signed		Day, Year)			
)) / / / /	1			D2316	/			1/10/0	78		
_	8		30. Name and address of person who	ueno, 902	Seton [(Type, P)ri∨∈	rint) e, Cumber	land,	MD 215	02				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra		back	3							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7:17A RONALD MCKINLEY HEERD SR JANUARY 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 9 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Months Days Hours 216-60-8554 **XX**M 2□ F 54 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Maryland Frederick 1 X Yes 2 No Walkersville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8743 Treasure Avenue 21793 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 😥 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any rigury or other traumatic event, the Megone. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Cement Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Heerd Katherine Toms ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon C. Heerd, wife 8743 Treasure Ave., Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Memorial Gardens Jan. 12, 2008 Frederick, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lic ns ²² Name and Address of Fallity ford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aprea 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy Otrgen Dependo 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the after death Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

1475

TAN67

#204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

S. GRISIAM

08-00207		Please		Print in Bl							egible.	000	0 0000	
Lillian Mae Hare		I- For State	State o	f Maryland	-	rtment o tificate o		and i	vientai r	тудіепе	Dan No	200	8 0082	
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Medical Exami		Lillian								Month January		Year	1838 hrs	
1		4a. Facility Name (if not in: Joppa Road and					4b. City, Tov Parkvill		ation of Dea	th		ounty of Death	ntv	
Funeral	-	5. Social Security Number			e (In vrs. la	ast birthday)	If Under		f Under 24H	rs. 8. Date of			nplace (State or	
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Mary r 28a-	Director	10e. Street and Number 3903 East	Tonn	Poad			10f. Zip C	ode 212	26		10g. Citizen of What Country? U.S.A.			
ith the 123a o		11, Marital Status	T	12. Was Decedent	Ever in U	S 13 W	as Decedent			Specify Yes or			can Indian, Black,	
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36 tin 72 than "dical]	plet	Elementary/Secondary	Secondary (0-12) College (1-4 or 5+) Secretary							Wa	rehous	se		
5-00 ed with sygience other	Completed by	17. Father's Name (First, N	viiddle, Last)						Mother's Nar	me (First, Middl				
Nilliam Walter Hare, Sr. Bertha L. Hale														
MD Baltimore Baltimore 106. Street and Number 106. Street and Numb														
and 2 and 2 ealth a		20a. Method of Disposition		=, DI.	20b. I	Place of Dispo	sition (Name	of cemete	erv.	Date	20c. Loc	ation - City or		
Nore Iges 1 It of H t: If if		1 X Burial 2 Cre		Removal from St	ate Si	crematory or of Abr	ther place) aham	s	J	an.14,	Bec	klevsvi	lle, MD	
nit. Partmer artmer oortan	D	4 Donation 5 Ot 21 Signature of Funeral S	her Specify: ervice Licens	* (/		Cemet	Name and A	ddress of				_	rtuary, Inc.	
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Physician /Medical		23a. Part I. Enter the disea failure. List only one	ase, or compli cause on eac	cations that caused h line.	the death	. Do not enter	the mode of	dying, suc	ch as cardiad	c or respiratory	arrest, shock	, or heart	Approximate Interval Between Onset and	
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Box 68760, e death certificate be the attending physic ed for use as the burned but the burned for use as the burned for the b	sician/Med	IF FEMALE: 23b. Was decedent pregna past 12 months?	int in the	23c. If yes, outcome 1 Live birth	me of preg		etal death	3	Ectopic preç	gnancy			Day Year	
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nl Re nn: Th rrtifical tor, pa	ပိ	25. Was case referred to	medical				26	i.Place of	Death (Che	ck only one)	33 2 110		2	
Division of Vital Records, P.O tall or Attending Physician: The law requires that the fact death. All Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	To B		10 Ho	ospital: 1 Inpatie	ent 2	ER/Outpatier		A Oth	her. 4 Nur	rsing Home 5		e 6 🗸 Othe	r: Scene	
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o the rithin 2 o the	Medical		al Examiner:	On the basis of exa										
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01		30. Name and address of Theodore M. Kin		_			111 Per	n Stree	et. Baltim	ore, MD 21	201			
	ate	31. Date filed (Month, Day	(Year)	32. Registra			W		., ==:	,				
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			Amend Item 4a& 1- State WCHD/SH 1/4 Registrar	2 State of Ma 4/07 per Di	aryland		artment of H <i>rtificate of I</i>			iene 200	8 00824
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	9	6.	Washington Cour Beverly Living C 5. Social Security Number 6. S		e (In yrs. las	t hirthday)	Hagers If Under Tyear		8. Date of Birth	Washi	ngton
	Funeral Director			7. A9	84	Yrs.	Months Days	Hours Min.	(Month, Day,		irthplace (State or Foreign Country)
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	ırylan show	b	10a. State 10b. County		10c. City, 7	Γown or Lo	ocation				10d. Inside City Limits
	he Ma 8a-f s otiffie	Director	Maryland Washin	igton		Hage	rstown				1 ☐ Yes 2 X No
	a or 2		10e. Street and Number				10f. Zip Code		10	0g. Citizen of What C	ountry?
	death ms 23	Funeral	18012 Putter Dri 11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	740 lispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	Rićan, etc.)	Black, Wh	nite, etc. White
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	nd 2 saith ar 27 is r trau		Martha Jane Hose	, ,,			_			n, Marylar	• /
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Ë	Page ment d ant: If ury or		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			= '	ing Ch. C	i i	1/5/08	Hagerstow	m, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		21. Signature of Furreral Service Lice	Man	nue	4	2. Name and Addre	, I		Funeral Ho	
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Вох	eath certificate be executed attending physician and for use as the burial-transit	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal de	eath 3	☐Ectopic pregnancy	y		23d. Date of d Month	lelivery Day Year
P.O. I	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the bunal-transit	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	time of dea	th 5[Other (specify)				
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	To the within To the complete	Me	29b. Signature and title of certifier	Cl 1.	. 1		29c. Licens	e number	1	9d. Date signed (Mo	
	-		I chan for	7/8W	2h		(-	2836	5	1-2-08	?
2	4-7		30. Name and address of person who	o completed cause of d	eath (Item 2:	3a) (Type,	Print)	treel-	Hage	rsteun	MD 21740
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	е			0		
	Registr	ar	IAN 0.3	2008	9. 201 O 4	K	Sparte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [3] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $_{\scriptscriptstyle{M}}^{\mathsf{a}}$ Year **Physician** Eleanor Η. Incheck 2008 7:33 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 619 North Park Drive Salisbury Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 □ M 2 🕽 F 189-14-1192 84 Director 3/10/1923 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Maryland Director Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 619 North Park Drive 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ white 3 Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wif Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatic event, the once. 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Chuba Mary Zizak ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer J. Incheck/husband 619 N. Park Dr., Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/3/07 Salisbury, MD 21. Signature of Funeral Service Lice 22 Hame-and Address Final Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 100 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 12 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 No Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes / a☐ Mo 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manny of Death 28b. Time of 28d. Describe how injury occurred After 1 or Attending Vatural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; ♭ 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. J. Mehra, M.D. 813 B Eastern

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

hone Daive Balisbury

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Certificate of Death Reg. No. 2008 00827															
	Physici /Medio		1. Decedent's Name (First, Middle, Last Howard Allen Jon	•						1	2. Date of Deat January	Day) 8	3. Time of Death 17:45P	М		
200	Examin		4a. Facility Name (If not institution, give 866 Ontario Stre		er)				Grac		th 4c. County of De						
×	Funeral Director		217-38-7000	x 7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months		If Under 2 Hours		8. Date of Birth (Month, Day, Oct. 1,	^{Ygar} 1953	9. Birth	place (State or Forei ntry) yland	gn		
	e Maryland sa-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harford			lavre		ace						10d. Inside City Limi 1 ☐ Yes 2 ☐ N			
	3a or 24	i Directo	10e. Street and Number 866 Ontario Stre	et			10f. Zip	Code 078			10	Og. Citizen of What Country?					
036	יערs after death at', or items 2 בתמיד וביתות	by Funerai	11. Marital Status 1 Never Married 2 Married 3 12 Widowed 4 Divorced	ecedent Ever in U.S. Forces? s 2 1 Na Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Spire Puer						cify Yes or No- lican, etc.)							
Maryland 21215-0036	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)										Bb. Kind of Business/Industry						
/land	should be file ind Mental Hy, marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Allen Cletis Jon	es							me (First, Middle, Maiden Sumame) na Fay Reed						
Man	nd 2 sho lth and 27 ie mu		19a. Informant's Name/Relationship (T				_				Route Number,			•			
altimore,	Pages 1 ar nent of Hea ant: if item ury or other	Wendy Jamison (Daughter) 20a. Method of Disposition 1 General 2 Scremation 3 Generoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State															
Baltii	permit. I Departm importar any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 24. Donation 5 Other (Specify) 24. A. Ferris & Co., Inc. 1/8/2008 West Chester, PA 25. Name and Address of Facility 26. R.A. Ferris & Co., Inc. 1/8/2008 West Chester, PA 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Funeral Home, P.A. 123. S. Washington St., Havre de Grace, MD 21078											£			
	Physician		23a Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that cau	sed the death h line.									Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):	01.011	<u> </u>									
_	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequ												
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O. Box 6	death certi e ettending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal t at time of de	death 3	Ectopic pro						te of deliventh	rery Day Year			
rds, P.	6 50	by	Part II. Other significant conditions co	ntributing to deat	h but not resu	Iting in the ur	nderlying ca	ause give	n in Part I.			_		the cause of death?	٧n		
Vital Records,	ysician: The law requires s certificate has been si director, page 2 should b	Completed									24a. Was ar autopsy perform 1 Yes 2	ned?	Were autoprior to codeath?	opsy findings availab empletion of cause o	ele f		
Vita	ician: sertifica ector, I	Be	25. Was case referred to medical examiner?	Hogoital:				05-		of Death	(Check only one						
Division of	ing Phy kiter thi uneral	Composition Composition															
Divisi	in Diffe	Certification:		4 Homicide determined building, etc. (Specify) 201. Cotation (Street and Number of Hural House Number, City or Town, State)													
	No Hospitel	edical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the be iner: On the basi and manner	s of examinati	vledge, death ion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, ar h occurre	nd due to the ca d at the time, da	use(s) and ma ate and place,	anner as :	stated. to the cause(s)			
)	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	L.H	Enry	23.0	290	License	number 54	7	29	ed. Date signe	d (Month,	Day, Year)			
	1		30. Name and address of person who c	MY MI). (00)	1 S.	Print)	MA	ve 1	Havi	re de	Grace	2 M	D 31078	7		
7	State Registrar 31. Date filed (Month Pay Year) 8 2008 32. Registrar's Signature																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** John Edgar Joy, Sr. Ам 6:30 January 08. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 25620 LOVEVILLE RD LOVEVILLE St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 117 M 2□ F 82 217-36-7805 13, 1925 Maryland July Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Director St. Mary's Loveville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20656 USA 25620 Loveville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pagés 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or iten any injury or other traumatic event, the Medical Examinatione. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 2 No ģ 3x Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Agriculture College (1-4or 5+) Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (George Edgar Joy Ann Missouri Wathen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 75 Loveville, MD 20656 Betty Lee Joy Thomas /Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State January 12. 1 ₺ Burial 2 ☐ Cremation Leonardtown, Maryland Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2008 22, Name and Address of Facility Signature of Funeral Service Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest 6 hours /Medical Due to (or as a consequence of): **Examiner** HypertenCoronary Artery Disease 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duality for as a nonsequance of) Examine or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus 11 years burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed' 1□ Yes 2k No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 🛛 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital e Funeral Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 ☐ Medical Examiner; within 2

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year,

JAN 1 C 2008

Eugene Guazzo, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

Maryland Infirmary, 25343 HURRY RD

29c. License number D002159

29d. Date signed (Month, Day, Year)

CHAPTICO

January 8, 2008

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		For 1_ State	State of Ma	aryland						ntal Hyg	ienę ()	08	008	329
		Registrar			Cei	tificate	e or L	Jeain			g. No.			
siciar	,	Decedent's Name (First, Middle, Last)								Date of Deat Month	Day	Year	3. Time o	
edica			bert D.	Kenne	y, 0.	S.F.S	•		J	anuary	9 20	308	2300	P M
mine	r	4a. Facility Name (If not institution, give s	treet and number)					Location	of Death		4c. Count	of Death	h	
		Annecy Hall					ilds				Ceo	cil		
ral		5. Social Security Number 6. Sex		e (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birth	hptace (State ountry)	or Foreign
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1		Maryland Cecil		Ch	ilds									- 44.10
Director		10e. Street and Number				10f. Zip				10	0g. Citizen of	What Cou	untry?	
2	3	1120 Blue Ball Roa					1916				Unite			
1		77	Was Decedent I Armed Forces?		i. 13. V	Was Deced I Yes, spec	ent of His	spanic Or n, Mexica:	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		ce - Amer ick, White	rican Indian, e, etc.	
u >	1120 Blue Ball Road 21916 United St 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1													
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1 2		15. Decedent's Educ (Specify only highest grade			16a. Deced		k done d	urina mos	st of working		16b. Kind of B	usiness/i	industry	
Completed		Elementary/Secondary (0-12)	College (1-4or 5	i+)		iest/					Do1-	igiou	10	
2	3	17. Father's Name (First, Middle, Last)			II.	IESL/			or's Nama /F	First, Middle, N			15	
å											naiden Jumai	110)		
۶	2	William A. Kenney							anor D					
9	1	19a. Informant's Name/Relationship (Typ								loute Number,			(ip Code)	
	1	Oblates of St. Franc	is de Sal					Pkwy		ington	•			
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	205. Pla	ace of Dispo metery, cren	sition (Narr natory or oi	ne of ther place	, ij	Januar _y	v 19.	20c. Location	- City or T	Town, State	
		4 □Donation 5 □ Other (Specify)		0	blate	Cemet	tery		2008	,,	Child	s, M	ID	
once		21. Sign ture of Funeral Service License	9		H-	Name an	Addres:	s of Facili	ity Funera	als, P.	Α.	5,		
a	ı	Dorned S.	Hickn							E1ktor		1921		
	İ	23a. Part1. Enter the disease, or complic shock, or heart lailure. List only one	ations that caused	the death.	Do not ente	er the mode	of dying	, such as	cardiac or re	espiratory arre	est,		Approximat Interval Bet	e ween
an	1	Immediate Cause (Final	20	Hara.	-0 1	10							Onset and	
al		disease or condition resulting in death)	Due to (or as	a conseque	prop of):		9					-	390	ST.
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i d	;	Sequentially list conditions, b. if any, leading to immediate	Due to (or as	а сопвеция	anea of):									
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2		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or dea	ain o	Other (spe	эспу)							
Completed by Physician/M		Part II. Other significant conditions cont	ributing to death hi	ut not result	ting in the ur	iderlyinn o	use awa	n in Part I		23e Did tob	acco use con	tribute to	the cause of o	ieath?
2			g to dod!! Di	at 110t 103an	ung in the th	radilying at	1030 9140	II III II GILI		1 □ Ye		-	obably 4 🖂	
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٦										perform	ned?	death?	2□ No	
8	1	25. Was case referred to medical examiner?						26. Place	e of Death (C	Check only one				
Į,		1 ☐ Yes 2 ☐ No Ho	spital: 1 Inpatie	nt 2 E	R/Outpatien	3 DO	A Othe	r. 4□Nı	ursing Home	5 Reside	nce 6 □Otf	ner (Spec	cify)	
c	1	27. Manner of Death	28a. Date of Injur (Month, Day	y Year) 2	28b. Time of Injury	21	Bc. Injury Work			. Describe ho				
at a		1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(, ,	y	М		es 2 🗆	No					
III.		3 Suicide 6 Could not be determined	28e. Place of Inju-	ry - At hom	ne, larm, stre	et, lactory	office		281	Location (Str City or Town	reet and Num	ber or Ru	ral Route Nun	iber,
la di		1101111010	Duliding, etc	. (эрөспу)						only or rown	, Jiaie/			
-		29a. Certifier 1 Certifying Physi	cian: To the best of	of my know	ledge, death	occurred a	at the time	e, date ar	nd place, and	due to the ca	use(s) and m	anner as	stated.	
Medical Certification:		(Check only 2 Medical Examine one)	er: On the basis of and manner sta	examination	on and/or inv	estigation,	in my op	inion, dea	ath occurred	at the time, da	ate and place,	and due	to the cause(s	i)
Z	1	29b. Signature and title of certifier	110			29c	License	number		29	d. Date signe	ed (Month	n, Day, Year)	
		V/1/2 9/1/	11 1	2)		/	79-		100	ź.	01/1	1/10		
	-	30 Name and address of person who com	poleted cause of a	eath (Itom '	23a) /Tuna	Print\		الدال	- X X		0-71	700		
)		30. Name and address of person who con	Hocal Cause of de	Darii (Irem S	412 S	Sah	La -	Plus	a Da	Ewark	DE	19711		
State		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ILO C	Ju-our.	an- 1	1000	* / / 0	NOVE	72			
-11:11÷			5.4	3										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Registrar

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760, ulor Attending Physician: The law continent

Physician /Medica 4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

Singh

Decedent's Name (First, Middle, Last)

For State Registrar

Physician

/Medical

Examiner

4b. City, Town, or Location of Death

Kang

Reg. No

Day

3, 2008

4c. County of Death

29d. Date signed (Month, Day, Year)

1/3/2008

St. Mary's

4:30 p M

2. Date of Death

January

		St. Mary's Hosp	ital		Leonard			St.	Mary's			
Fune Direct		225-47-5594	1 5 M 2 □ F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 4,	ıy, Year)	9. Birthplace (State or Foreign Country) Pakistan			
pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion				101 1-11-01-11-1			
aryla shov	-	Tod. State Tob. County		roc. City, Town of Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🕱 No			
e Ma-f	Director	Maryland St. M	ary's	Leonar	dtown				I ∐ Yes 2 ANO			
iff th	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?			
th w 23a	<u></u>	21975 Philip Dri	ve		206	50		US	A			
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌁 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:)	Was Decedent of H f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Speci	ce - American Indian, ick, White, etc. fy: Indian			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examiner must be notified at	Completed t	15. Decedent's 8 (Specify only highest g	Education	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most of work	king	16b. Kind of E	Business/Industry			
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ent.	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's Name	e (First, Middle					
arylances and Mental 1 s marked of 1 umatic even	10 B	Bhaghat Sin	gh Kang			Balwant	Ka	ur	Binder			
shou mar	1-	19a. Informant's Name/Relationship	<u> </u>	19b. Mailir	a Address (Street	and Number or Rui						
Ma d 2 s d 2 s th ar th ar trau		Kulbeer Dhillon/				Drive, L						
Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami		20a. Method of Disposition 1 ☐ Burial 2 【● Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or Town, State te Hall, MD			
Iting Iting												
Demi	ouce	21. Signature of Funeral Service Lice	Clos B MO	0817 8	rinsfiel 0195 Thr	d-Echols ee Notch	Funeral Rd., Ch	Home, arlotte	P.A. Hall, MD 20622			
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the one cause on each line	ne death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between			
Physicia /Medic	al	Immediate Cause (Final disease or condition resulting in death)	a. Left Ba	asal Gangl consequence of):	ia Hemmo	rhage			Onset and Death			
vecuted vand lateralsit	er le	Sequentially list conditions, if any, leading to immediate acuse. Lifter this original cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Cc. Due to (or as a consequence of):										
'GS, P.O. BOX 68/60, uires that the death certificate be executed signed by the attending physician and id be detached for use as the burlansit	Medical E	IF FEMALE:	▲ d									
dS, P.O. BO) Lires that the death or signed by the attend d be detached for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	/			ate of delivery onth Day Year			
that ned be det	<u>ح</u>	Part II. Other significant conditions	contributing to death but	not resulting in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to the cause of death?			
		Diabetes Melli					1 🗆	Yes 2X No	3 ☐ Probably 4 ☐ Unknown			
On or VITal MECOI ding Physician: The law req n. After this certificate has beer funeral director, page 2 shou	Complete	Atrial Fibrilla					24a. Was autoj perfo	osy ormed?	Were autopsy findings available prior to completion of cause of death?			
		Coronary Artery 25. Was case referred to medical	Disease				1□ Yes	2 X No	1 ☐ Yes 2 ☐ No			
Sicia sicia cert rectc	Be	examiner?	Hospital:		Oth	26. Place of Deat						
Phys rathis	2	1 Yes 2 No 27. Manner of Death	XX npatient	2 ER/Outpatien	3 DOA	4 ☐ Nursing Ho						
VISION OF VITA Attending Physician: r death. ector: After this certified by the funeral director, I	ation:	1 ▼ Natural 5 ☐ Pending investigation		(ear) 28b. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2 □ No	28d. Describe I	how injury occu	rred			
DIVISION ospital or Attending hours after death. uneral Director: After ly filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		r - At home, farm, stre (Specify)	eet, factory, office		28f. Location (City or Tox	Street and Num vn, State)	ber or Rural Route Number,			
DIN e Hospital or / 24 hours after e Funeral Dire letely filled in b	dical C	29a. Certifier Certifying P (Check only one)	hysician: To the best of miner: On the basis of e and manner state	xamination and/or inv	occurred at the tile estigation, in my contract	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and m date and place	anner as stated. and due to the cause(s)			

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rajbinder S. Gill,

29c. License number

Hollywood, MD 20636

D56096

Registrar

DHMH 17 Rev 1/2001

State

BA 15+1

10/28/1930

3

ORIGINAL

Beaus G. Sparte

32. Registrar's Signature

BELLIN, MD 21811

37 BROAD ST. SWITE 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylan	-	artment of F		nd Me		jiene eg. No.	2008	00832
		-	Decedent's Name (First, Middle	, Last)					2	. Date of Dea			3. Time of Death
	Physici /Medic		Ruth Elizabeth	Lancey						January	1	2008 Year	7:20 A M
1	Examir		4a. Facility Name (If not institution	, give street and nui	nber)		4b. City, Town, o	r Location of	Death		4c.	County of Death	1
			Anne Arundel Me	dical Cen	ter		Annapol:	is			Anı	ne Aruno	del
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min. 8	. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
١.	Director		166-24-4570	ILIW ZIALF	79	Yrs.				oct 16,			nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d, Inside City Limits
	Maryll f sho	Į.	100	1 1		c .							1 □Yes 2 X No
	the 28a-	Director	MD Anne A 10e. Street and Number	rundel	Uro	fton	10f. Zip Code			1	I0g. Citiz	zen of What Cou	intry?
	3a or		1472 Nestlewood	Court			21114			ī	JSA		
	ms 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of F	lispanic Orig	in? (Speci	fy Yes or No-		14. Race - Amer	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 🎢 Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Formed Formed In The Section 1	2 X No		If Yes, specify Cub 1 ☐ Yes 21 No	an, Mexican, Specify:	, Puerto Ri	can, etc.)		Black, White Specify:	
5-0036	hour tural	Completed by	15. Decedent		ates.	16a. Dece	dent's Usual Occur	oation			16b. Kir	W N . nd of Business/li	ite
15	in 72 n "ng Medic	blet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	1.40r E 1)	(Give	kind of work done DO NOT use retire	during most d)	of working	·			,
2121	d with giene ar tha the I	E O	12	College (-401 5+)	Telle	er				Ban	k	
P	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (i	First, Middle,	Maiden	Surname)	
/lai	uld b Menta Irked Itlc e	မှု	Herman Carl Tes	smer		_		Elean	or El	Lizabet	h M	cLain	
Maryland	2 sho and Is ma		19a. Informant's Name/Relationsh	, , , ,			ng Address (Street						ip Code)
2	and lealth m 27 her to		Jack E. Lancey/	nusband	ant r		Nestlewo						
O.	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation		Siale		osition (Name of matory or other pla		Dat			cation - City or T	
Baltimore,	permit. Page Department Important: II any Injury o		4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service				te Cremato					sville,	
Ba	permit. Departr Imports any Inju		Bevery L	Hout	MO1	251 Be	2. Name and Addre sing Home everly L.	Crema Heckr	tion otte,	Servic P.A.	e Cla	P.O. Boz rksville	x 784 e, MD 21029
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat	h. Do not en	ter the mode of dyi	ng, such as o	cardiac or i	respiratory arr	rest,		Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition	a	30	cherio	ez h	11.7					Onset and Death
1	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):							
3.	Clar.	į.	Sequentially list conditions, if any, leading to immediate	b	or as a conseq	uence of):							-
	uted 1 ansit	Examiner	Cause (Disease or injury that initiated events			,							
oʻ	exect an and rial-tra		resulting in death) Last	C. Due to	(or as a conseq	uence of):							
8760,	cate be executed oblysician and the burial-transit	dical		d									
9	ntifica ng ph as th	Med	IF FEMALE:								-1		
P.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → Yo 9 ☐ Unknowh	1 ☐Live t	come pf pregna pirth 2□Feta nant at time of c own	l death 3	⊒Ectopic pregnanc ⊒Other <i>(specify)</i> _	у			2	23d. Date of deli- Month	very Day Year
	s that ned b	by Pt	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
rds	w requires been sig should be	q pe								1 □ Y	es 2[3 □ Pro	obably 4 □Unknown
ပ္က	aw re Is bee 2 sho	plet								24a. Was a		24b. Were au	topsy findings available
or Vital Records,	The lav ate has page 2 :	Completed				_				autop: perfor 1□ Yes	med? 2 □ No	death?	ompletion of cause of 2 □ No
İta	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Check only or	-	1	
<u> </u>	dilis	2	1 ☐ Yes 2 →	Hospital: 1	mpatient 2	ER/Outpatie		4 LI Nur	rsing Home	e 5 ☐ Resid	ence 6	3 □Other (Spec	cify)
		ä	27. Manner of Death 1 Death 5 □ Pending		of Injury th, Day Year)	28b. Time o Injury	Wo			d. Describe h	ow injur	y occurred	
Sio	or Attending after death. Director: Afte in by the fune	cati	2 Accident investig 3 Suicide 6 Could r	ot bo	of Injune - At he	omo farm et	M 1 ☐]Yes 2□N -		f Location (C	troot on	d Number or Du	val Flauta Number
Division	al or A s after or al Direct ed in by	Certification:	4 ☐ Homicide determ		ng, etc. (Specil		reet, ractory, office		20	City or Tow			ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (g Physician: To the Examiner: On the b and man									
		Σ	29b. Signature and title of Certifie	mm	5		29c. Licens	se number	6 a c	2	/	e signed (Month	
	IZ EG,		30. Name and address of person	who completed caus	se of death (Item	n 23a) (Type,	Print)	V 11120	(h	y Lea	MN	211	15
	Sta	ite	31. Date filed (Month, Day, Year)		tegetrar's Signa			100	- V			214	
34	Registi		JAN U	3 2008	Eleve	K,	Speed 5						
DH	MH 17 Rev 1/2	nn1							-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	-210		101	ertificate of Death		2008	00833
*	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Francis Paul Miles		January	2, 2008	7:40 a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			25475 Mary Kay Way	Hollywood		St. Mary's	
U	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	lace (State or Foreign try)
С	Director		220-16-9053		01/08/19	924 Mary	land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	/anyi	ō	Y	_			1 □Yes 2 🛛 No
	the A	Directo	Maryland St. Mary's Hollywoo	10f. Zip Code	100	g. Citizen of What Cour	
	with a or						,
	eath nusi	Funeral	25475 Mary Kay Way 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sr		Jnited Stat 14. Race - Americ	
	iner d	들	Armed Forces? 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
39	ırs af al', or xam	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No II Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: B1a	o le
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	1	6b. Kind of Business/Ind	
75	hin 7; In "n Medi	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of worl DO NOT use retired)	ting		
2	d with	E O		l Servant	τ	J.S. Govern	ment
	should be filed nd Mental Hygi marked other imatic event, t	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma		
<u>a</u>	Aents Aents rked ric ev	T0 E	Joseph Miles	Mary Mad	eline Col	line	
Maryland	s 1 and 2 should be f f Health and Mental I item 27 Is marked of other traumatic eve	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Ru			Code)
	ulth a		Paul B. Miles/Son 2164	3 Atlanta Street,	Lexinotor	n Park. MD	20653
re	es 1 an of Heal fitem 2 rother		20a. Method of Disposition 20b. Place of Disposition	osition (Name of ematory or other place)	Date 2	Oc. Location - City or To	wn, State
Ĕ	permit. Pages Department of I Important: If it any Injury or o		i Zabuliai 2 Dolelliation 3 Dhellioval Ilotti State	's Cemetery 01/0	8 / 2008 T	To 11	M = === 1
altimore,	mit.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Br	o/∠uuo ⊢n insfield	Funeral Ho	Maryland me P Δ
m	any any			22955 Hollywood Ro			
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	221		-	Onset and Death
	/Medical		disease or condition resulting in death) Due to (r as a c insequence of):				
B	Examiner		Topocco	eddiction			
ĬĠ.		ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	2000000000			
	od d ansit	Examiner	Cause (Disease or injury that initiated events c.				
oʻ	exectan an an rial-tr		resulting in death) Last Due to (or as a consequence of):				
68760,	icate be executed physician and s the burial-transit	ical	d				
89	# B	Physician/Medical					
ŏ	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	ery
m m	dear te att	sicis		Other (specify)		Month	Day Year
о. О	at the by the tache	hys	9 ☐ Unknown				
ر ک	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
ecords,	equire en siç ould to		COPD		1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown
ပ္က	aw ress be	Completed	Syvertims for		24a. Was an	24b. Were auto	psy findings available
ř	The lage	E O			autopsy	ed? death?	inpletion of cause of
		Be C	25. Was case referred to medical	26. Place of Deal	1 Yes 2 In (Check only one)		2 No
>	ysici is cel direc	.0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor		ce 6 □Other (Specif	ν)
0	g Physer this leral di	n: T	27. Manufr of Death 28a. Date of Injury 28b. Time		28d. Describe how		
0	nding I ith. r: After e funer	tio	1 ✓ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	r Attender death	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, s	treet, factory, office		et and Number or Rura	l Route Number,
	al or Att s after de il Direct ed in by 1	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the cau	use(s) and manner as s	tated.
	n 24 n 24 n FL	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occu	red at the time, dat	te and place, and due to	the cause(s)
	To th	ž	29b. Signaturgland title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
			Vychael X. Byranic	7 D31952		01-03-	-0X
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			-
			MICHAEL S. SZKOTNICK	C, MD,			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

		For State	State o	f Marylan		artment of H		d Men	-	-	2009	3 00	1831
		Registrar 1. Decedent's Name (First, Middle)	e, Last)			illicate of t	Dealli	2. [Date of Dea	Reg. No.(ath	1000	3. Time	of Death
Physici /Medio		Walter Fr	ancis Mar	shall				Na.	Month	Day 3	7/)/	8 1.	255M
Examir		4a. Facility Name (If not institution				4b. City, Town, or	r Location of De	eath 7			County of De	ath	
		Union Memorial				Baltimo		1 1	Baltimor				
Funeral Director		5. Social Security Number 220–32–6085	6. Sex 1 XX M 2□ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Date of Birt Mo <i>nth</i> , Day 1y 31	y, Year)		irthplace <i>(Stai</i> Co <i>untry)</i> iryland	te or Foreign
pg >		Usual Residence of Decedent 10a, State 10b. County		10c Cit	y, Town or Lo	ncation						10d Inside	City Limits
/anyia f shoved at	JO.	,	more City		Baltim								es 2XXVo
the f	Director	10e. Street and Number	more city	<u> </u>	Daitin	10f. Zip Code				10g. Citiz	en of What (Country?	
h with 23a ol st be		2709 Fenwick Av	enue			2121	18				USA		
r deal	Funeral	11. Marital Status	Armed Fo		.S. 13. 1	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify uerto Rica	Yes or Non, etc.)	- 1	4. Race - An Black, Wh	nerican Indian, nite, etc.	,
paritiniore, Infarytiatio Z IZ I3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myorinjury or other traumatic event, the Medical Examiner must be notified at ance.	by Fi	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	I If Yes, Gir	ve 71.		1 □ Yes 2 No	Specify:				Specify:	B1ack	
72 hou 72 hou 'natura dical E	Completed	15. Deceden (Specify only higher	t's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of t	working		16b. Kin	d of Busines	s/Industry	
within sne.	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		urity Gua				Hos	spital		
Hygied Hygie		17. Father's Name (First, Middle,	Last)		500	urrey oue	18. Mother's N	Name (Fir	st, Middle,				
lid be fental rked o	To Be	William Xavier	Marshall				Elizal	beth	Evely	yn Cu	ırtis		
and A man		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Street	and Number or	r Rural Ro	ute Numb	er, City or	Town, State	, Zip Code)	
and and man man man man man man man man man man		Nancy Ann Mars	shall / Wi			Fenwick	Avenue		timo				
ages 1		20a. Method of Disposition XXBurial 2 □Cremation		State	emetery, cre	osition (Name of matory or other place	· Ja	nuary				or Town, State	
Dalliffication Pages Separation of mportant: If it any injury or once.		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service		Una		norial Garde 2. Name and Addre		2008				wn, Mar al Home	
Deparii Impol any ir		Michael	KLaro	liner	` .	0. Box 270,		_	_			GE MOILE,	
		23a. Part1 Enter the disease, or shock, or heart failure. List	complications that conly one cause on	caused the deat	h. Do not ent	ter the mode of dyir	ng, such as card	diac or res	spiratory a	rrest,		Approxir Interval	Between
Physician		Immediate Cause (Final disease or condition	_a (1	ardio	ovas	cular	. C	011	a ps	e		Onset ar	nd Death
/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):				{				
4	er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):		_						
cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S E	ESRID									
cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to	(or as a conseq	uence of):								
physic physic the b	dical	N N	d										
ox of the control of	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome pf <u>pr</u> egna						2.	3d. Date of c	felivery	
death death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Feta nant at time of d		□Ectopic pregnancy □ Other (specify) _	у				Month	Day	Year
at the lat the	Phys	9 Unknown			100- 10- 10- 10-				00- Did.			t- 0	
ires th signed	by	Part II. Other significant condition	ons contributing to a	eath but not res	uiting in the u	nderlying cause giv	en in Paπ I.			obaccous Yes 2[to the cause	or deatn? ☐Unknown
w requires to been signer should be a	eted							-	24a. Was				
The lav e has age 2 a	Completed						<u>. </u>	-	autor perfo	psy ormed?/	prior t death	autopsy findin o completion o	of cause of
lian: T	Be Co	25. Was case referred to medical	1				26. Place of I		1□ Yes neck only c	2 No	1 □ Y	es 2 No	
hysical	To B	examiner? 1 Pes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursin	ng Home	5 🗆 Resi	dence 6	□Other (S	pecify)	
ing Phy After thi	ou:	27. Manner of Death 1 Natural 5 ☐ Pendin	ig I	of Injury oth, Day Year)	28b. Time o Injury	Wor		28d.	Describe I	how injury	occurred		
ttend death. ctor: /	cati	2 ☐ Accident investig 3 ☐ Sulcide 6 ☐ Could r	not be	of injury - At ho	ome farm str		Yes 2 □ No	28f	Location (Street and	Number or	Rural Route N	Jumber
al or A safter or A safter of al Direct of in by	Certification:	4 ☐ Homicide determ	ined build	ling, etc. <i>(Specil</i>	<i>fy)</i>	reet, factory, office			City or To		i wamper or	ridiar riodie r	varnber,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno pasis of examina oner stated.	owledge, deat ation and/or in	h occurred at the til ovestigation, in my o	me, date and pl opinion, death o	lace, and occurred a	due to the it the time,	cause(s) date and	and manner place, and c	as stated. lue to the caus	se(s)
vithir To th	Me	29b. Signature and title of certifie	00:00	_		29c. Licens						onth, Day, Yea	
		Maun	Bull	MM		DO	0588 N. C	60		JL	IN 3	, 200	8
10		30. Name and address of person		_	n 23a) (Type,	Print) 3333	N. C	ALV	ERT	ST	ر ، کار	ite 5	55
Sta	ate	31. Date filed (Month, Day, Year)	DHILLUN 32.	gistrar's Signa	ature	BAL	TIMOR	LE,	MD	41	218		
Regist		JAN 0	7 500°	all the	6								
DHMH 17 Rev 1/2	2001				1	s ille						-	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00835 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month 12:04P^M John Muhammad January 3,2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 578-84-3121 Director April 2,1962 Wash., DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits Director 1 XYes 2 No Md. PG District Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or Items 23a or 2132 County Road 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 Types 2 No If Yes, Give 1981 – Year or Dates: 1987 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced 1987 Black Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Printer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Teaque Mary McArthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 SE County Road rict Heights Vicki Muhammad/wife : If Item 27 or other t Md. 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1/12/08 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F Suitland, 3910 Silver Hill 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on mich line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Arrest Min. /Medical Due to (or as a consequence of) Examiner Tracheal Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Trach Dislodged physician and ts the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Type B Aortic Dissection 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Old Cerebral Vascular Accident 24a. Was an autopsy performe Hypertension 2 No 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ပ 2 ER/Outpatient 3D DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hours aft le Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Function (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JAN 7, 2008 lenno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green, 3001 Hospital Dr., Cheverly, Md. 20785 Linda D. M.D. 32 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Physi /Med Exam

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or pro-

	1 - State Registrar		Cert	tificate of I	Death	Re	g. No.				
	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death			
cian Iical	Claude Wil	lliam MOSER				Januar		8 2:57 AM			
iner	4a. Facility Name (If not institution, give street Washington County			4b. City, Town, or Hagers	r Location of Death S town	1	4c. County of De Washin				
1	5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	irthplace (State or Foreign Country)			
r	217-20-1197	8	5 Yrs.			Nov. 11	,1922 Ma	ryland			
	Usual Residence of Decedent 10a. State 10b. County	10c, City,	Town or Loc	ation				10d. Inside City Limits			
5	Maryland Washington	,,	liamsp					1 □ Yes 21 No			
ect		,,,,,				140	10g. Citizen of What Country?				
Funeral Director	10e. Street and Number 16827 Tammany Manor	Road		10f. Zip Code	10	U.S.A.					
l en	A	Vas Decedent Ever in U.S. rmed Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.			
Be Completed by Fi	If	☐Yes 2X No Yes, Give Year or Dates:		□Yes 2XINo	Specify:		Specify:	white			
ete	15. Decedent's Education (Specify only highest grade com	6b. Kind of Busines	ss/Industry								
횬	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)										
Ö	0	U	tri	ıck drive			milk co	mpany			
B	17. Father's Name (First, Middle, Last)	34			18. Mother's Nam	ne (First, Middle, M	,				
2	Clarence Ira						len Green				
	19a. Informant's Name/Relationship (Type. P Ruth Mosser - wife	Print)					City or Town, State Liamsport	, Zip Code) , MD 21795			
	20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of atory or other place	ce)		0c. Location - City	or Town, State			
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	Broa	dford	ing Churc	ch Janu 2 2	ary 7,	Hagerstow	n, Maryland			
ŝ	21. Signature of Funeral Service Licensee	0 .		Name and Addre			Funeral				
5	Kabultollan	kin	41	5 East W	ilson Bl	vd., Hage	rstown, N	Maryland 21740			
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	ns that caused the death.	Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between			
	Immediate Cause (Final disease or condition	ASPIR	ATI	IN P	NEM	ONIA		Onset and Death			
	resulting in death)	Due to (or as a conseque		,,,,							
		, , ,	,								
e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):								
Examiner	Cause (Disease or injury that initiated events										
Exa	that initiated events c c	Due to (or as a conseque	nce of):								
g											
/Medical											
		yes, outcome pf pregnand					23d. Date of	delivery			
Physiciar	1 Type 2 TNo	∐Live birth 2 ☐ Fetal d ☐ Pregnant at time of dea		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year			
hys	9 Unknown 9	Unknown									
γP	Part II. Other significant conditions contribut		ng in the und	derlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?			
Completed by	DYSPHAGIA	<u> </u>				1 ☐ Ye	s 2 □ No 3□	Probably 4 ☐Unknown			
ete						24a. Was an	24b. Were	autopsy findings available			
E E		-		·		autopsy	prior t death	o completion of cause of			
ပို	25. Was case referred to medical				26 Plans of Doo	1 Yes 2sth (Check only one	1 1 Y	es 20 No			
o Be	examiner? 1 Yes 2 No Hospit	tal:	R/Outpatient	3□ DOA Othe	or:		nce 6 □Other (S				
1: To		Ba. Date of Injury 2	8b. Time of	28c. Injur		28d. Describe how		респу)			
ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No						
rtifica	o□ outside 6□ Could not be	Be. Place of injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,			
S	29a, Certifier TE Certifying Physician	n: To the best of my knowle	adaa daath	occurred at the #	no doto cert ele	and due to the					
Medical Certification:	(Check only 2 Medical Examiner: (On the basis of examination and manner stated.	n and/or inve	estigation, in my o	pinion, death occu	irred at the time, da	ite and place, and d	as stated. lue to the cause(s)			
Σ	29b. Signature and title of certifier # . C	hotani		29c. Licenso		29	d. Date signed (Mo	nth, Day, Year)			
	, , ,			ν	> 885.	>	0110	4/08			
	30. Name and address of person who completed the HABIB A CHO		3a) (Type, P	F ANTI	ETAM S	5T. , H	AGERST	4/08 010N, MD			
tate trar	31. Date filed (Month, Day, Year) JAN 0 7 2008	32. Registrar's Signatur		1							

Registrar
DHMH 17 Rev 1/2001

		For State Registrar	State of Ma	aryiano /	-	ficate of L		ivientai H	ygiene Reg. No	2008	8 00	83
Physic /Med		Decedent's Name (First, Middle, Lase SHIRLEY YVONNE	MOSER					2. Date of D	Do	01, 20	3. Time of 23	of Death
Exami		4a. Facility Name (If not institution, give	e street and number)		41	o. City, Town, or	Location of Deat			. County of De		
** *	ė#	WASHINGTON COUNTS 5. Social Security Number 6.8		/In ure lasth	irthday) II	HA(Under 1 Year	GERSTOWN If Under 24 Hrs		lieth		HINGTON	
Funeral Director	_		1 M 2 X F	e (In yrs. last bi		onths Days	Hours Min.	8. Date of E (Month, I	Jay, Year)	939	Birthplace (State Country) NARYLANI	or Foreig
/land low at		10a. State 10b. County		10c. City, Tov	vn or Locati	on					10d. Inside (City Limits
Mar a-f sh ified	ż	MARYLAND WASHI	NGTON			H	IAGERSTO	JN			1 ∑ Y <i>e</i> s	s 2 No
th the or 28% e not	Funeral Director	10e. Street and Number				10f. Zip Code	IIIOIAID IO	,,,,,	10g. Cit	izen of What	Country?	
ath wi	ral	1158 LUTHER DRIVE	<u> </u>				1740			U.S.A		
er deg Items ner m	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was	Decedent of Hies, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or Noto Rican, etc.)	10-	14. Race - Ar Black, W	merican Indian, hite, etc.	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🙀 N If Yes, Give Year or Dates:			Yes 2⊠No				Specify:	WHITE	
thin 72 h le. an "nate Medica	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		a. Decedent (Give kind life. DO	's Usual Occupa d of work done of NOT use retired,	ation during most of wo l)	rking	16b. K	and of Busines	ss/industry	
filed within Hygiene. vther than "	S	12				CASHIE					SCHOOL	
be fill Had H	Ba	17. Father's Name (First, Middle, Last					18. Mother's Na	, .	-	Surname)		
should and Mer marke	은	ROBERT EDWARD CUT		100	h Mailine A	ddroos (Ctrast a	ROSIE R			T Ot-1	7: 0 (1)	
and 2 s ealth an n 27 is i		ROXIE KELBAUGH/N		!			and Number or R ER ROAD,					1705
s 1 ar f Hea item (20a. Method of Disposition		20h Place o	of Disposition	n (Name of		Date	7		or Town, State	11//
Page lent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other Special		1		ory or other place CEMETER	1	5/2008	POO	MCDODO	, MARYLA	\ NTO
mit. partm portal		21. Signature of Fluneral Service Lice	nsee		22. Na	ame and Addres	s of Facility			ationa.		TIND
permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		Jan Wille	w Paul	M. Dean	BAS	T FUNER	AL HOME			Maryla		713
		23a. P-rt1. Enter the dise se, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not enter th	ne mode of dying	g, such as cardia	c or respiratory	arrest,		Approxima Interval Be Onset and	ate etween
Physician		Immediate Cause (Final disease or condition	a asr	Wash	â	mem	omei				Unset and	Death
/Medical Examiner		resulting in death)	Due to (or as	consequence							48ho	
		Sequentially list conditions,	b. Due to (or as	a consequence	of):						9 aay	10
uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duc to (6) 43 t	consequence	01).							
execunand ial-tra	Exal	resulting in death) Last	C Due to (or as	a consequence	of):							
tificate be executed g physician and as the burial-transit	edical	(d									
ag d ∰		IE EENAN E.										
ath ce ttendi	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		h 3∐Ect	opic pregnancy				23d. Date of o		Vaca
he deg	Physician/N	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 □ Ot	her (specify)				MOULT	Day	Year
The law requires that the death cer tte has been signed by the attendin page 2 should be detached for use		Part II. Other significant conditions of	contributing to death bu	it not resulting i	in the under	lying cause give	en in Part I.	23e. Did	I tobacco ı	use contribute	to the cause of	death?
uires sign Id be	d by							1	Yes 2	□ No 3□	Probably 4	Unknowr
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The lavate has	Jmo							aut per	opsy formed? 2 (2 No	prior t death		cause of
, , , , , , , , , , , , , , , , , , ,	Be C	25. Was case referred to medical	-				26. Place of Dea			1 □ Y	es ZIINO	
hysic this ce	To E	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/O	utpatient (B□ DOA Othe		Home 5 ☐ Res		6 □Other (S	pecify)	
Ing P		27. Manner of Death 11☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe	e how inju	ry occurred		
Attending Physician: r death. ector: After this certific by the funeral director,	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No					
tal or Al s after c al Direc ed in by	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home, to . (Specify)	arm, street,	factory, office		28f. Location City or To	(Street an own, State	nd Number or e)	Rural Route Nui	mber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on miner: On the basis of and manner sta	examination at	e, death oc nd/or invest	curred at the timi igation, in my op	ne, date and place pinion, death occ	e, and due to th urred at the time	e cause(s e, date an) and manner d place, and c	as stated. due to the cause	(s)
To th Withir To th	Me	29b. Signature and title of certifier	MIN			29c. License				-	onth, Day, Year)	
		· wanger j	The state of the s			D28	365			-2-0	5	
5H-8		30. Name and address of person who	completed caluse of de	368 W	(Type, Prin	"Sheel	- Hag	estern	1 19	0-2	1740	
	ate	31. Date filed (Month, Day, Year)		r's Signature	-		0					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death **Physician** CECIL SR. PRUITT 2008 9:50 A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19817 TANBARK WAY BRINKLOW MONTGOMERY Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 25 **Funeral** 1**⊠**M 2□F Months Days Hours 578-12-4259 87 Director 1920 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Montgomery Brinklow iral", or items 23a or 28a-f sl Examiner must be notified Director 1 ☐ Yes 2 🛪 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20862 United States 19817 Tanbark Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No <u>ک</u> Specify. Specify: WWII White 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed er than "natur , the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnee. Electrical Electrician 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Essie Smith John Pruitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gayle Peter / Daughter 19817 Tanbark Way, Brinklow, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/05/08 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home <u>500</u> P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Entrol e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic PKSTructing /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by sign. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s 1□ Yes 2 No To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury ours after death.

Neral Director: A
filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Physician DO05569 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOX 4000 20832 MATHUZ 108 Olyey, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 00839

		1- For State	Certifica					g. No.	0 0000
Physic ledical Exam	ian/	Registrar 1. Decedent's Name (First, Middle,Last) Kamareon Lamir Pa	almer	-			2. Date of Death Month January 5,	n Dav Year	3. Time of Death 0825 hrs
		4a. Facility Name (if not institution, give street and number)		4b	. City, Town, or	Location of		4c. County of Deat	<u> </u>
		Peninsula Regional Medical Center			Salisbury	T		Wicomico	
Funeral Director		n/a 1XM 2_F	(In yrs. last birth	day) Yrs.	Months Day		24Hrs. 8. Date of Birth Min. 11/07	(MM/DD/YYYY) 9. Bi Forei /2007	
any		Usual Residence of Decedent 10a. State	0c. City, Town o	or Locatio	n	·			10d. Inside City Limits
*	<u>ة</u>	Maryland Somerset	Prince	ess A	nne				1 X Yes 2 No
Maryls	Director	10e. Street and Number	<u> </u>		10f. Zip Code		10	g. Citizen of What Cou	intry?
ith the		11. Marital Status 12. Was Decedent E	ver in IIS	13 Was	21853		n? (Specify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is narked other than "natural", or items 23a nor 28a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 Married Armed Forces?	K No	If Yes		n, Mexican, F	Puerto Rican, etc.)	White, etc.	rican/
hours a		15. Decedent's Education (Specify only highest grade comp	d		s Usual Occupa st of working life		nd of work done se retired)	16b. Kind of Business.	
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+ n/a n/a		n/a	•			n/a	
5-0036 led within 72 Hygiene. other than 'the Medical	5	17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Middle, M		
21215-0036 ald be filed within 7 Mental Hygiene. marked other than c event, the Medica	B B	Robert Lee Elmore					dgette Shar		
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Importants: If time 27 is marked o Importants: If time 27 is marked o	6	19a. Informant's Name/Relationship (Type, Print) Bridgette S. Palmer/mother	· 1	1575	Progre	ess La	ne, Princes	ss Anne, MI	21853
ore, es l and of Heal If iten		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	e cremato	ry or other			Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify:	Spring	hill	Memory		1/12/08	Hebror	
Bal permit Depar Importinjury		21 Sign Ture of Funeral Service Licensee	CFSP	1 22 No	DITOWAY	Funer	al Home Pro Rd., Salisk	ofessional	Association
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	ne death. Do not	t enter the	e mode of dying	, such as car	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Sudden infar		syndro	ome (SIDS)			Death
		or condition resulting in death) Due to (or as a consection by	quence of):						
	ner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause	quence of):						
_	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of):						
760, icate be executed physician and the burial - transit	鱼田	d			<u> </u>				
60, ate be ex hysician e burial	Medical	X UNPENDED AMENDED, #23a, 27, per #23a, 27, per 23c. If yes, outcome		3/11/0	D8 TT			23d. Date of delive	n'
5876 rrtificat ling ph	an/N	23b. Was decedent pregnant in the past 12 months?	2	Feta	al death 3	Ectopic	pregnancy	Month Month	Day Year
Box 687 The death certific The attending p	ysician/	1 Yes 2 No 9 Unknown 9 Unknown	me of death 5	Oth	er (Specify)				
P.O. Es that the Ganed by the G	1 4	Part II. Other significant conditions contributing to death	but not resulting	in the ur	nderlying cause	given in Par		bacco use contribute t	
S, P.O. uires that the n signed by a detached	ed by								obably 4 Unknown
cords, I aw requires as been sig 2 should be	Completed						24a. Was autop	sy prior to	autopsy findings available completion of cause of
Rec The I ficate I	S						1 ✓ Yes		
Tital sician: is certi lirector	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatien	t 2 ✓ ER/Ou	utpatient		Othor	Check only one) Nursing Home 5	Residence 6 Oth	er:
ion of Vital Rectending Physician: The eath. for this certificate the funeral director, page	-	27. Manner of Death 28a. Date of Injury	b	Time of In		ury at Work?	-	now injury occurred	
ion ttendii death.	aţio	1 X Natural 5 Pending 2 Accident Investigation			1	Yes 2			
Division of Vital Records, pital or Attending Physician: The law requinours after death. After this certificate has been si filled in by the funeral director, page 2 should it	Certification:	3 Suicide 6 Could not be determined (Specify)	ıry - At home, fa	rm, stree	t, factory, office	building, etc	28f. Location (S or Town, S		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -transi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, dea ination and/or ir	nth occurr	ed at the time, o	date and place on, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
E » F »	Me	29b. Signature and title of certifier				se number		29d. Date signed (M	
NOR		Panelly Touthers, MD			0.0	.M.E.		January 6, 2008	3
0 04		30. Name and address of person who completed cause of de Pamela E. Southall, MD Assistant Medic		r 111	Penn Stree	et, Baltim	ore, MD 21201		
Regi	tate strar	31. Date filed (Month, Day, Year) 32. Jegistrari	s Signature	La	40				
DHMH 17 Rev 1		JAN 1 4 / 1010 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		IGINAL			OCME		

08-0	0166
Luis	Padilla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uis Padilla	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 0084										
Physician/ ledical Examine	Registrar 1. Decedent's Name (First, Middle,Last) Luis Padilla		2. Date of Death Month Day January 6, 2008	Year 3. Time of Death 1411 hrs							
y the s		Ib. City, Town, or Location of Death Crofton	4c. C	ounty of Death ne Arundel							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 581 – 19 – 2757 1 M 2 F 51 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	-	Foreign Emorland							
my	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits							
daryland 28a-f show any 1 at once.	MD Anne Arundel Crofton		10g Citizer	1 Yes 2 No							
the Maryland a or 28a-f sh iffied at once	10e. Street and Number 2408 Lizbec Court	10f. Zip Code 21114	US								
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the M-fical Examiner must be notified at once To Be Completed by Funeral Director		s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto—F Yes 2 No specify:	Rican, etc.) Rican	t. Race - American Indian, Black, White, etc. Puerto-Rican pecify:							
5-0036 led within 72 hours after they write after they content than "natural", he M. Yeal Examiner Completed by		nt's Usual Occupation (Give kind of voorst of working life. DO NOT use reties Statistician	red)	d of Business/Industry S.Government							
21215-0036 add be filed within 7 Mental Hygiene. marked other than cevent, the Mr first	17. Tallet 3 Hallie (1 list, Middle, Edsty	18.Mother's Name Elanor	(First, Middle, Maiden St Jones	urname)							
ID 21215-003 should be filed within and Mental Hygiene. 77 is marked other that event, the Mental Hygiene. To Be Comi	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Red Kite Pt. Or)									
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental 1 Important: If item 27 is marked injury or other traumatic event, To Be	20a. Method of Disposition 1	sition (Name of cemetery,	Date 20c. Lo	cation - City or Town, State bela, Puerto Rico							
Baltin Sermit. P Separtme Importan	21. Signature if Funeral Service Licensee 22.	Name and Address of Facility Bea	all Funeral Bowie MD 2	Home 0715							
Physician Medical	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Contact gunshot wound of Due to (or as a consequence of):	nead									
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ted nisit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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Devicing as the burst of the Device of the D		etal death 3 Ectopic pregn		Date of delivery Month Day Year							
P.O. B sthat the de		underlying cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown							
cords, law requires has been signatured by 2 should be			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
ital Recition: The sector, page	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check nt 3 DOA Other Nurs		nce 6 🗸 Other: Scene							
1 of Vi	1 V Yes 2 No 28a Date of Injury 28b, Time of	Injury 28c. Injury at Work?	28d. Describe how inju								
Division o spital or Attending sours after death. neral Director: After filled in by the fune	Natural Accident Acci		subject shot 28f. Location (Street and Street nd Number or Rural Route Number, City								
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		urred at the time, date and place, ar	nd due to the cause(s) and	ct. Crofton, MD							
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investiged and manner stated. 29b. Signature and title of certifier	ation, in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) Date signed (Month, Day, Year)							
	My Mi Mi D	O.C.M.E.		uary 7, 2008							
of M	30. Name and address of Person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201									
Star Registra	te 31. Date filed (Month, Day Year) 32. Registrar's Signiture										
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	Physic	an/	1- For State Registrar 1. Decedent's Nam			yland		ificate o		TIG WICHTER	2. Date of D	Reg. No.	20		me of Death
Med	ical Exam										Month Day Year 2200 hrs				
E.			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 461 Hillcrest Drive Aberdeen						ith	4c. County of Death Harford					
	Funeral Director		5. Social Security I		6. Sex		ge (In yrs. las	st birthday)	If Under 1 Y		i.a.	,	/DD/YYYY) 9	oreign	`
	Director		560-04-		1 M 2 X	F	51	Yr			Feb.	13,1	956	Country)	W. VA
	v any		10a. State	10b. County			10c. City, T	own or Loca	tion						Inside City Limits
	yland I-f shor	tor	MD 10e. Street and Nu		rford		Aber	deen	1406 75- 0-4-			T40= 0i4	of W/b -4		Yes 2 No
1	he Mar or 28a	Director	461 Hil		Dr.				10f. Zip Code 2100			10g. Citizen of What Cou			
1140	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status		12. Was	Decedent	Ever in U.S.		as Decedent of I	Hispanic Origin? (ean, Mexican, Puer			14. Race - A White, e		ndian, Black,
	er deatl ', or ite r must	Funeral	Never Marri Widowed	ed 2 XM	arried 1 Y	es 2	X No		Yes 2 X		to Rican, etc.)				
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	36 n 72 hc nan "na iical Ex	Completed	Elementary/Sec	ondary (0-12)	Colle	ge (1-4 or	5+)		_	ife. DO NOT use r	etired)				
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	1215 be file ental H erked o	Be (Charles							Nancy (
	MD 21 d 2 should th and Me n 27 is man	ြင	19a. Informant's Na Jack Qu					t .		reet and Number o				State, Zip (Code)
	e, M 1 and 2 Health item 2		20a. Method of Dis	position				ace of Dispo	Hillcre		Date Abe	20c.	Location - Ci	2100 ty or Town	
	Pages Pages nent of ant: If			Cremation Other S	n 3 Remov	al from St	atc	ematory or o	ric e C	1/·	15/08	Wes	st Ches	ster.	PΔ
	Baltimore, bermit. Pages I an Department of Hea Important: If ite		21. Signature of Fr					22.	Name and Addre	ess of Facility -Cargo Fu	ıneral	Home.	P.A.	0001	
	Physician		23a. Part I. Enter the	ne disease, or	complications th	at caused	the death. D	Do not enter	the mode of dvir	ng, such as cardia	or respiratory	arrest, sh	ock, or heart	App	proximate Interval
7	/Medical		failure. List or Immediate Cause			Border se and	line ca	rdiomyo	pathy wit	h mild ath	eroscler	otic c	ardiovas	scul i	tween Onset and Death
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1	50, ite be e	Aedio	IF FEMALE:				rME,g87		08 TT			23	d. Date of de	livery	
	BOX 6876U, re death certificate be ex the attending physician red for use as the burial	sician/Medi	23b. Was decedent past 12 months		1 L	ve birth	t time of deat	2 F	etal death	3 Ectopic preg	nancy		Month	Day	Year
	BOX e death co	by Physic	1 Yes 2	No 9 🗸 Un	rnoum '	nknown	time or deal	^{tn} 5 0	ther (Specify)						
	es that the digned by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								_	tobacco use contribute to the cause of death? 'es 2 No 3 Probably 4 ✔ Unknown			
	Sords, P.O. law requires that the has been signed by 2 should be detach					-					- 24a. W				findings available
	e law r e has b ge 2 sho	Completed	-								pe	utopsy erformed?	prio dea	r to comple th?	etion of cause of
	tal Kec cian: The certificate ector, page	Be Co	25. Was case refer	red to medica	ı E				26.Pla	ace of Death (Che		es 2 1	No 1 ₩	Yes	2 No
	NOT VITAL ING Physician: After this certifications and a second physicians.	To B	examiner?	2 No	Hospital: 1			R/Outpatien			sing Home 5		ence 6 🗸 (Other: Scer	ne
	on of noting Pt. th.		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No												
	UNISION Of VITAL RECORDS, to or Attending Physician: The law required and retoreath. In Directorath. The this certificate has been so led in by the funeral director, page 2 should I	Certification;	Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number								oute Number, City				
i	UIVI Hospital or 24 hours afte Funeral Dir tely filled in	Cert	4 Homicide determined (Specify)												
	the hin	Medical	29a. Certifier (Check only one) 2		miner:On the ba	sis of exa				date and place, a on, death occurre					se(s)
	To To	Med	29b. Signature and		and mann	er stated.				nse number			Date signed		
			O.C.M.E.							Jar	nuary 13, 2	2008			
			30. Name and addr		who completed			*	Street. Baltin	nore, MD 212	01				
特許		tate	31. Date filed (Mon			63	ar's Signature		AP .						
	Regis	trar	JA	IN I	LUUU MA	13 24Q	E 630	A 234	CC						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mildred Ross 0340 Jan 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dalisbury Wicomica lisbur Rehaba Nursing Ctr. ear If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min. 1 M 2 XF Months 215-10-4944 93 Director 5/29/1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show at r 28a-f sh notified 1 ☐ Yes 2 ☑ No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 300 Lemon Hill Lane 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. white 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic Pages 1 and 2 should be filed vent of Health and Mental Hygir other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles DeFaleo Mary Schly 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Ross/daughter-in-law 52 Anchor Way Dr., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State t of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/2/08 Salisbury, MD 21. Signature of Funeral Service Liver R. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Call RINO 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown cate has been signed by , page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes certificate 2 No 2 H/0 or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3 DOA 1 🖂 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Robins

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Ye

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W

32. Regionar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month Mary Ann Reed January 03 2008 1:23 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown Mary's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 X F Director 214-66-4819 52 11/25/1955 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show at 1 ☐ Yes 2 No be notified Director Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a must ! 49722 Cedar Lane 20628 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23. Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Welch Virginia Jenkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I other tra Craig Bruce Reed / Husband Cedar Lane Dameron, Maryland 20628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages I Department of H Important: If ite any injury or ot 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 1-5-2008 Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) scord of ENTARCTION **Physician** ue to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE Se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2.2 No 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division To the

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650 William D. Boyd II, 31. Date filed (Month, Day, Year)

JAN 0 7 2008 32. Registrar's Sign

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Registrar AMEND#31 See#32, 1/3/08, BW, MCO Certificate of Death Reg. No. 00844 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** January 1, 2008 Seymour Rand 5:50P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Adventist Healthcare Springbrook Nursing Ctr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July12,1913 9. Birthplace (State or Foreign Country)
New York, NY Funeral Months Days Hours 1**X** M 2 □ F 077-01-8950 94 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Maryland Prince George's Adelphi 1 □Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10525 Truxton Road 20783 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Economist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be William Rand Sadie Rosenthal ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erna Rand -wife 10525 Truxton Road Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Lebanon Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA Jona 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each i.e. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 **Physician** Welght 1 ound LOSS and /Medical Due to (or as a co sequence of): Examiner Cancer taye >r. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 brillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Demen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo page 2 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred : After 1 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or To the Hospital or within 24 hours af To the Funeral D completely filled 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 2, 2008 D31001 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)
Stuart J. Turkewitz, M.D. 7500 Greenway Center Drive, #430 Greenbelt, Maryland 20770 Stuart J. Turkewitz, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 03** 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN 2008 1048 /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Medical Center WICOMICO 8. Date of Birth (Month, Day, 12-23 Birthplace (State or Foreign Country) **Funeral** Year) 27 Months Days Director 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show be notified at 1 □ Yes 2 No Princes Director omer 10f. Zip Code 10g. Citizen of What Country? USA "natural", or items 23a adical Examiner must b by Funeral Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married s, Give 1946 or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 1947 Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eper 1 and 2 should be filed w epartment of Health and Mental Hygien reportant; If item 27 is marked other things injury or other trainments. hanic 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Elizabeth War 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Greenwood School Ra daughte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Vet-Cem. 1-7-081 Beulah, md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 917 W. Isabella St Bennie Smith Salisbury, md 21801 FUNERAL Home 23a. Part1. Enter the dise shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Carcimma 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page perform certificate 25. Was case referred to medical examiner? 2 🗌 No or Vital director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After Division 5 ☐ Pending investigation veral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

Peninsula Regional Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Pgistrar's Signature

B. Silvia,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:14 JANUARY 2008 William David Ridenour 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se: 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1X M 2 T F July 8, 1929 78 Maryland 218-24-9350 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔽 No MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 13804 Pennsylvania Ave. 21742 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Custodian 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward L. Ridenour Martha L Grimm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21742 Mark J. Grim/Son 13804 Pennsylvania Ave., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Smithsburg Crematory 1/10/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) -60 MOTON Due to (or at a consequence of) morany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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this funeral

After t

physician

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the within 2

death.

after death filled in by the

e Funeral

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or ? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner Physician/Medical \$ Completed Be (Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant

autopsy perform 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2<mark>⊟*</mark>No 1 ☐ Yes

27. Manner of Denth

1-Natural

2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation

28a. Date of Injury (Month, Day 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) -09-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or Muhamad Wuscom 1170

1126 Opas Court, Hages Stown, maryland 21 mg

31. Date filed (Month, Day, Year)



Year,

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2008 3:45 AM M Richard V. Reppert 1 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/30/1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days West Virginia 1 □XM 2 □ F 87 233-26-3420 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 32 Martinique Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🎾 🛣 No Specify Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Field Operations Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde Reppert Ida Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 I 32 Martinique Circle, Ocean Pines, MD 21811 Suzanne Reppert / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Its
any injury or or
once, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/3/2008 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee The Burbage Funeral Home 108 William St., Berlin, MD 21811 Powl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final YPOXEMIC KESPIRA TORY **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending Natural s after dea...ral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 10+1 614 Easternshore Dr Salisbury MD 21804 Yogesh Vohra M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1312 Januar 2008 Marguerite Virginia RESH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 79 3, 1928 Maryland 213-24-9592 Nov. Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at TY Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 930 Noland Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Her own home 0 Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h permit. Pages 1 and 2 should be Department of Health and Mr Important: If Item Bertha Belle Mowen Harry Milton Bruffy Mills 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 930 Noland Drive, Hagerstown, Maryland 21740 Jeffrey Resh - Grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/08 4 Donation 5 Dother (Specify) Hagerstown, Maryland Broadfording Mem. Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home Frod L. Velas 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 40 Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner raishulmmarm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the death certificate be executed burial-transi has a consequence of): resulting in death) Last or Vital Records, P.O. Box 68760, ding physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has 2 No certificate 1□ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division (Month, Day Year Injury or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

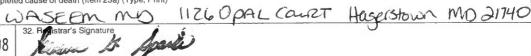
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State Registrar

31. Date filed (Month, Day, Year)

JAN 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2323

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 26 State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Ralph Franklin Royce, Sr. 335 January 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/24/1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 215-34-3605 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f sh notified MD Washington Hagerstown 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 21742 1006 Potomac Avenue US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Caretaker Cemetery es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be May Irene Myers Lee Hammel Royce, Sr. ပ 19a. Informant's Name/Relationship (Type. Print)
Joseph L. Royce / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 184, Funkstown, MD 21734 Joseph L. Royce / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Smithsburg Crematory 01/09/2008 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Disease Dronar /Medical Due to (or as a consequence of): Examiner nen monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed Sepsis attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has this certificate 1□ Yes 2☑No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: ို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af le Funeral D letely filled i Medical 29a, Certifier LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within ? To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 116108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-8

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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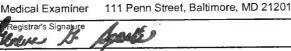
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00015 State of Maryland / Department of Health and Mental Hygiene Byron A. Roman 1- For State Certificate of Death Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ January 1, 2008 1511 hrs **Medical Examiner** Byron Alberto Roman 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Silver Spring Montgomery 11508 Elkin Street Apartment 2 Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ForeigGuatemala Hours Months Days 219-49-7877 10/11/1971 Director 36 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 XNo Silver Spring Md Montgomery · 28a-f shov Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20906 Guatemala 2430 Lady Meade Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married Guatemalan White Yes 2 X No -1 X Yes 2 4 X Divorced If Yes, Give Year No specify. Specify. Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. Highschool Maintenance Supervisor 21215-0036 other t 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luis Alberto Roman Maria Imelda Ismatul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .00 Baltimore, MD 20932 Rootstown Terrace Ashburn, Va20147 Rony Geovany Roman/Brother item 27 i 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition t; If it Gate of Heaven Burial 2 Cremation 3 Removal from State ||/12/2008 Silver Spring, Md Donation 5 Other Specify PHILIP D. RINALDI FUNERAL SERVICE, P.A. 21. Signal re of Funeral Service/License Columbia blvd.Silver Spring.Md20910 9241 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Madacat Death a. Acute alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 7.28a-f. perME.g875, 1/19/08 TT attending physician or use as the burial -The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown n signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? this certificate has performed? No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner' Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury Certification: 1 Yes 2 X No Natural Pending unk the FNd 1/1/2008 Fnd 2:53 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, of Found in laundry room of office building, etc. Suicide or Town, State) determined (Specify) 1508 <u>Elkin St.</u> Silver SPring, MD apartment building Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

the Hospital or Attending Physician: thin 24 hours after death. within 24 hours after death To the Funeral Director: completely

> Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Mark) T 2008

30. Name and address of person who completed cause of death (Item 23a)



and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 2, 2008

Medical

State

Registrar

one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No

	Physician
	/Medical
4	

1 - For State Registrat 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:00P M January William Michael Selby 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, Year) May 12,1943 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Days 64 Yrs 213-38-8634 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10d. Inside City Limits 10a. State show 1 ☐Yes 2X No must be notified Director MD Carroll Westminster 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 4135 Salem Bottom Rd. U.S.A. 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ White 3 Widowed 4 Divorced Be Completed permit. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Tractor trailer driver transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Selby Audrey Hunter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty G. Selby - wife 4135 Salem Bottom Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Gardns 1/14/2008 Eldersburg, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses att New Windsor, MD 21776 310 Church St. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METHICILIN RESISTANT SMAPH SERSIS ~-P:P.h **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown CHROWIC CHYLOTHORAX Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No COLON CANCER 24a. Was an autopsy performed? Yes 2 No ITIS DORY OF IMMUNE THIZOMBO CYTOPENIA or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) DOUB HOUSE 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: # death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled i 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 031660 10/2008 an as SCHWIN IN M 8 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER MARYLAND STONER Avenue THOMAS K GALUNIIIMA 291 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 JAN 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30 AM J. Harry Senkbei1 an 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Rehab + Nursing Ctr.

5. Social Security Number 6. Sex 7. Age (In yes. last birthday) Wicomica lisburg Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Min 1 X M 2 □ F Hours Director 206-18-1626 81 1-19-1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Vincent Street 21804 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item: ledical Examiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Baltimore, Maryłand 21215-003(Completed by 3 Midowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Contractor self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked P Augustus Senkbeil Lola Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Albert W. Senkbeil - son 912 Vincent Street, Salisbury, MD 21804 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-3-2008 Crematory of Delmarva: Delmar, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Lice 705 E. Main Street, Salisbury, Maryland 21804 23a. Part . Enter the disease, or compl shock, or heart failure. List only or ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any least the limit data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Be Completed by 1 | Yes 2 | No 3 | Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1□ Yes 1 ☐ Yes 2 ☐ No 2 ... Mo 25. Was case referred to medical 26. Place of eath Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yo 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? vithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Watural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Robins 20 0 3 2008 Registrar's Signature State Registrar

	4	. Decedent's Name (First, Middle,	(ast)				2. Date of Deat	giene leg. No. 2008	3. Time of Death
Physician		Kitti Frantz Sie	,				Month	Day Year	0 4 0 11
/Medical Examiner	2	a. Facility Name (If not institution,			4b. City, Town,	or Location of Death	Lanuary	4c. County of Dea	
	- 1		rsing Home		Havre	de Grace If Under 24 Hrs.	0.0-4-4.004	Har	tard
Funeral Director		Social Security Number 6 245-38-7113 Sual Residence of Decedent	1. Sex 7. Age (In y	78 Yrs.	Months Days		8. Date of Birth (Month, Day, May 27,	, Year) C	irthplace (State or Foreign Country) rginia
yland		0a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
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D36	2	Marital Status Never Married 2 Married Midowed 4 □ Divorced	Armed Forces?		If Yes, specify Cull 1 ☐ Yes 2 ☒ No	ban, Mexican, Puerto	Rican, etc.)	Black, Whi	
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arylan should be nd Mental marked c						Violet P	olonsky		
Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important; if item 27 is marked other any injury or other traumatic event, ti once. To Be Cr		19a. Informant's Name/Relationship			•			r, City or Town, State,	'
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Baltimore, permit. Pages 1 at 29 permit. Pages 1 at 29 permit of Hea mportant; if item any injury or other page.		4 □ Donation 5 □ Other (Spe			ris & Co. 2. Name and Addr			West Chest	
Balti permit. Departr Imports any Inju	X	Main C	3e Olma			46		uneral Hom re de Grac	e, r.a. e, MD 21078
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/Medical Examiner		resulting in death)	Due to (or as a cons		٠.	0	0	0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:15 P M 4, 2008 January Sidney Elmore Sorrels /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F 99 Yrs 29, Mississippi 1908 428-07-1779 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County Hygiene. other than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland | Saint Mary's Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 USA 30012 Arbor Hills Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Printer s 1 and 2 should be filed v if Health and Mental Hygie item 27 is marked other to other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmore Sorre1s Lillian Sidney ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30012 Arbor Hills Way, Mechanicsville, MD 20659 Mrs. Helen E. Sorrels, Spouse : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 1/16/2008 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) Marvland Veterans 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licensee 30195 Three Notch Road, Charlotte Hall, Maryland M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) urdiorespina 24-**Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infilted late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Anemi and burial-trar Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year ţ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by details þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Onknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? Ves 2 No page 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🔲 Yes P this 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? lospital or Attending P thours after death. After t Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. P.O. Records, Division or Vital 24 hours a Hospital

> State Registrar

filled in by

To the within 2.

Medical

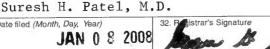
31. Date filed (Month, Day, Year) 2008 3 0 MAL

4 Homicide

(Check only one)

29b. Signature and title of dertifier

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0062213

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician JEFFRIES BETTY** STEWART 01 08 2008 2130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 6. Sex **Funeral** Hours Days 217-28-9612 82 Director MARYI AND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director **CRESAPTOWN** MD ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21502 UNITED STATES 12605 PENBROOK STREET 'natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other trainment. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISTRIBUTION SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ ELIZABETH JEFFRIES PORTER MARSHALL PORTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL COSNER DAUGHTER 12605 WINCHESTER ROAD CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State FROSTBURG MEM PARK 1-11-2008 FROSTBURG, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. m00547 bwe13 60 W. MAIN STREET, FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Diseas **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 TYes 2 No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 1 Tes 2 No 2 ☐ ER/Outpatient 3 1 XOOA Certification: To $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 □ Pending 1 Yes 2 No investigation

Division or Vital Records, P.O. Box 68760, d To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

> b State

Medical

6 ☐ Could not be determined

Leon

3 ☐ Suicide

29a. Certifier

31. Date filed

4 Homicide

(Check only

29b. Signature and title of certifie

Registrar

1 Deritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVIZ

00856

		-	For State Registrar	State of Ma	ryland /		tment of H <i>ificate of L</i>			giene- Reg. No.	.000	00000	
			Decedent's Name (First, Middle, Last	")					2. Date of Dea	ath		3. Time of Death	
	Physicia /Medic								January	7 3,	2008	3:22 p. M	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		1	County of Death		
			4 W. Maple Street				Funksto	own			ashingto	on	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)		place (State or Foreign intry)	
	Director	1	217-28-6525 Usual Residence of Decedent	/	5				Aug. 2	8 19.	32 Mary	yland	
	yland		10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits	
	B.f.	ctor	Maryland Washing	gton	Funk	stown						1X☐ Yes 2 ☐ No	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	s 23s	rai	4 W. Maple Street	12. Was Decedent E		40.144	21734				JSA 4. Race - Amer	ione Indian	
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Forces?		IS. VV	Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	o Rican, etc.)	· '	Black, White		
980	urs af	þ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		11	☐ Yes 2X No	Specify:			Specify: Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ant, the Madical Examiner must be notified a	Completed	15. Decedent's Ed		16	6a. Decede	nt's Usual Occup	ation during most of wor	kına	16b. Kin	d of Business/li		
2	ithin it	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. Di	O NOT use retired)	nii g				
2	led w tygier her th	ပိ	12	0		Acc	counting	18. Mother's Nam	on /First Middle		y Govern	nment	
and	ntal H ed ot	Be	17. Father's Name (First, Middle, Last)								Sumanie/		
Maryland	thouic d Me mark matic	2	Richard O. Melze: 19a. Informant's Name/Relationship (7		1	9b. Mailing	Address (Street a			Williams If Route Number, City or Town, State, Zip Code)			
Ma	olth er 27 is r treu		Jack Melzer - Bro					, Funkst					
ē,	s 1 a f Hee item othe	- 2	20a. Method of Disposition		20b. Place	of Dispos	tion (Name of atory or other place	1	Date		cation - City or T		
Ē	Page nent o int: If		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					ory 1/5/	08	Hagei	rstown.	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than. Instural; or items 23a or 28a-f show any figury or other treumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licen	see m.		22.	Name and Address	ss of Facility M	INNICH I	UNER	AL HOME		
	20E = 9		200 /////Limito 415 E.Wilson Blvd., Hagerstown, Md. 21740										
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Crecke Cancer LY muntum										
	Examiner			Due to (or as a	a consequen	ce ol):							
	444	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
	outed d ansit	Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events c										
oʻ	e exec en an irial-tr	Exa	resulting in death) Last Due to (or as a consequence of):										
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Вох	eath certif attending for use as	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of delivery Month Day Year			
P.O.	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tille ot death	. 5	Other (specify)						
	The law requires thet the death cert sie has been signed by the attending page 2 should be detached for use	by Pr								23e. Did tobacco use contribute to the cause of death?			
rds	quire on sig uld b								10	1 Yes 2 No 3 Probably 4 Unknown			
O လ	e lawre hes bee je 2 sho	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of	
č	The ete he	E O							perfo	autopsy performed? performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
/ita	cien: ertific	Be (25. Was case referred to medical examiner?				12.		ath (Check only o	(Check only one)			
of \	Physicien: this certificanal director, I	ဥ	1 1 1 43 2 2 2 1 NO	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)							cify)		
Division of Vital Records,	ding h. After funer	tlon	27. Manner of Death 28a. Date of Injury 28b. Time ol 28c. Injury at Work? 2 □ Accident investigation M 1 □ Yes						28d. Describe how injury occurred				
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á	el or s efte i Dire	Certification:	4 Homicide	building, etc	c. (Specify)				City or To	wn, State))		
	To the Hospitel or Attending Physicien: The i within 24 hours eiter death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	edicai (29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of the basis of and manner sta	examination	dge, death and/or inv	occurred at the tirestigation, in my o	πe, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	e signed (Monti	h, Day, Year)	
			Michael 1.	Muhn	1 A	10	0	41667		1	. 4.0	8	
51	4-4		30. Name and address of person who	completed cause of d		3a) (Type, F		ical C	anau	In	Bareer	town Mp	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 7	32. Registra	ar's Signature		houle	UMI C	111100		NJ-ZIV	,,	
	3,01		JAN U I	July	Ne S	J. 19							

X State 29b. Signature and title of certifier

Yahia M.

31. Date filed (Month, Day, Year)

yalia

Registrar DHMH 17 Rev 1/2001 25500

29c. License number

D50883

29d. Date signed (Month, Day, Year)

Pt.Lookout RD. Leonardtown, MD 20650

January 9, 2008

and manner stated

and address of person who completed cause of death (Item 23a) (Type, Print)

Tagour

2008

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M.D.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? | | | | | | Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 11:55 P M January 2008 Molly Vere vonSchwerdtner /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harkord 626 Country Club Road Havre de Grace If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗑 F 217-20-1825 83 06/24/1924 **Director** Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ?7 is marked other than "netural", or items 23a or 28e-1 show traumatic event, the Medical Examiner must be natified at 10b. County 1 ☐ Yes 2 No Director Havre de Grace <u>Harford</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 626 Country Club Road 21078 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ™ Widowed 4 □ Divorced White Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Hairdressing 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be William Albert Hash Mary Hobson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 626 Country Club Road, Havre de Grace, MD 21078 Molene C. Stenger (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 14 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 1/5/2008 West Chester. PA Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CANCER 1 Pes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ ₩6 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled i t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month A) 32. Registrar's Signature **2008** State A Miles Registrar

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2325 Рм 2008 January Betty Imogene Willis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil SunBridge Care Center Elkton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DEC 31, 1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🗓 F Kentucky Yrs. 234-40-7023 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County ?7 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Mudical Examinar cust be notified at 1 X Yes 2 □ No Directo E1kton Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with i ment of Health and Mental Hygiene.

The files TS is marked other then "neturel," or items 23a or item yor other them the "item Example in the interment or worth, it is walked. 21921 United States 303 Skipjack Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ð White 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Matilda Campbell Perry Hatmaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 455 England Creamery Rd., North East, MD 21901 Perry A. Willis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition January 12, 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: if any injury or once. Union, Maryland 2008 4 □ Donation 5 □ Other (Specify) Union Cemetery 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unknown Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician /Medical Due to (or as a consequence of) **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner o the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 No this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 2 Accident by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/11/2008. 20023322 Delidon & MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 38, Electer MD 2/92/ 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State de la constante 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** JANUARY 1031 WINSTEAD 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER RANDALISTOWN BALTI MORE HOSPITAL NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 410-58-7452 SEPTEMBER 7, 1937 Tennessee Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Directo** Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 450 Avenel Circle, Apt. T-1 21158 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 retail grocery store meat cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Pearl Winstead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau Robin Turner/ daughter New Windsor, MD 21776 1220 Overleigh Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Pipe Creek Cemetery 1/16/2008 nr. Linwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tun of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home athanine 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final MULTIORGAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SERRGILLOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): OBSTRUCTIO Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the burial ATRIA Physician/Medical 1 BRILLATION 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ABSTES 24a. Was an autopsy Division or Vital 1 Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 271 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42827 JAHUANY 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abballah Kafrouni

DHMH 17 Rev 1/2001

State

Registrar

STOL OLD COUNT

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

THE STATE OF

RANDALL STOWN

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<i>y</i>	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	1 ^{Day} , 2008	3. Time of Death 12:35 A M
	/Medic		Bessie Gray Whanger 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	January	4c. County of Dea	
	LXaiiiii		Lorien at Riverside		Belcamp			Harfor	rd.
	Funeral Director		213-20-7411 1 1 M 2 M F 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 17	,1926 Mar	rthplace (State or Foreign ountry) Tyland
	/land ow		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Loc	cation				10d. Inside City Limits
	e Man la-f sh tified	ctor	MD Harford	Edgewood	d				1 □ Yes 2XINo
	with the	Director	10e. Street and Number		10f. Zip Code			0g. Citizen of What C	ountry?
	death v	eral	1114 Chipper Drive 11. Manital Status 12. Was Decedent Ever i	n U.S. 13. V	21040 Was Decedent of H f Yes, specify Cuba			U.S.A.	erican Indian,
2-0030	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married I ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	f Yes, specify Cuba 1 □ Yes 2⁄፫ No		Rican, etc.)	Black, Whi	_{ite, etc.} Vhite
ה ה	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	ting	16b. Kind of Business	:/Industry
7	withir jene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		maker	<i>'</i> /		In Home	}
ana	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Gordon Poland				e (First, Middle, a a Willis	Maiden Surname)	
, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Buddy Whanger (Spouse)	1114	Chipper	Dr. E	ral Route Numbe dgewood ,	r, City or Town, State, MD 21040	
pallillore	ges 1 If of He If iten or oth		I I I I I I I I I I I I I I I I I I I		sition (Name of natory or other place			20c. Location - City or	
	nit. Pa artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Senylde Licensee		erris & Co			Vest Cheste	er, PA
0	Depar Impor any Ir		*KUDENHOUHLACIENT	Il Ta	Name and Address rring-Cai erdeen, M	rgo Funer Marvland	al Home, 21001-3	, P.A. 3399	
V			23a. Part1. Enter the disease, or complications the caused the caused the cause on each line.	leath. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
-	Rbysician /Medical		Immediate Cause (Final disease or condition resulting in death)	re t	o the	nue			Onset and Death
	Examiner		Due in jor as a con	equence of):	4 1 1				
0	P #	ner	Sequentially list conditions, if my leading to the course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Due to (or as a c	sequence of:					
8	and I-trans	Examiner	Cause (Disease or injury that initiated events c	sequence of):					
00/00	rificate be executed ng physician and as the burial-transit	cal E	d						
_	rtificating physical	Medical	IF FEMALE:						
. DO	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of de Month	elivery Day Year
٢.	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
Š	equire sen sig ould b	ted b	Dementia				1□Y	es 2Mo 3⊟P	robably 4 Unknown
משר =	The taw r cate has be page 2 sh	Completed	- Coronary Arte	ry 1),seas	ce	24a. Was a autops perfor 1 Yes	prior to	autopsy findings available completion of cause of
V 150	sician; certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		t 3 DOA Othe	26. Place of Doat			
5	Ing Phys After this uneral di	on: To	27. Mann r of Death 1 Death 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injur	y at k?		ence 6 □Other (Spe ow injury occurred	∍cify)
70171	or Attend fter death Director: in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - A building, etc. (Sp	At home, farm, streecify)		Yes 2 □ No	28f. Location (Si City or Town	treet and Number or Fi n, State)	iural Route Number,
נ	Hospital 24 hours a Funeral l etely filled	Medical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the tin vestigation, in my o	me, date and place, ppinion, death occur	and due to the c	ause(s) and manner a	is stated. ue to the cause(s)
	To the within To the compl.	Me	29b. Signature and title of certifier	\bigcap	29c. License	e number	_2	29d. Date signed (Mon	nth, Day, Year)
			Mamil Mill	/ m	DDD	195X	3	Januar	y 11, 2001
	10		30. Name and address of person who completed cause of death	M m 23a) (Type, F	Print) & I	an/ A	root	Aber	deen.
	Sta	te	31. Date filed (Mohth, Day, Year) 32. Registrar's S	ignature	u /	0.10	1 41)	Maryl	and 2100
	Registr	ar	TAN 1 7 2008 8	10 - 10.	Tara			/	

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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

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Baltimore,

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature a

EDDIE NAKHUDA,

2008 7

31. Date filed (Month, Day, Year)

JAN 1

Kacal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D

32. Registrar's Signature

2300 DULANEY VALLEY ROAD

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21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-f per int 88762-14-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** James Patrick Walsh, Sr. January 12 2008 1706 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9 Glen Creek Circle E1kton Ceci1 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Months Days Hours JAN 25. Director 053-34-9673 64 1943 New York Usual Residence of Decedent 10b. County Suffolk with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State "natural", or items 23a or 28a-f show edical Examlner must be notified at East Setauket 1 Yes 2 No Director Cecil-E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 Ledgewood Circle 11733 9 Glen Creek Circle 21921 United States Pages 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
nn: If Hem 21 is marked or ther than "natural", or Items 23.
nn: If Hem 27 is marked or ther than "natural", or other traumatic event, the Medical Examiner must any or other traumatic event, Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ 3

Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) City of New York Elementary/Secondary (0-12) 12 College (1-4or 5+) Sergeant Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Patrick Walsh Winifred Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Walsh, Jr./Son 33 Darlise Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. January Farmingdale, New York 1 X Burial 2 □ Cremation 3 □ Removal from State St. Charles Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 18, 2008 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFAR OTON acaron of **Physician** /Medical s a consequence of) Examiner nouse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, CA physician a the burial-Due to (or as a consequence of): Physician/Medical nding p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation nours after death.

Ineral Director: A

y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year)
THURRY 14, 2008 29c. License number 29b. Signature and title ofcertifier LECIL CTY DERIT MEDICAL EXAMINACE erson who completed cause of death (Item 23a) (Type, Print) / 06 5 Tree 30. Name and address of BUW ASVIOK JBRAMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 7 2008 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Marian Elsie Whitcomb January 10, 2008 7:25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Asbury-Solomons Health Care Center Solomons If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Months 1 M 2 V 92 August 24,1915 United Kingdom 213-44-6751 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Calvert Solarans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. 216 20688 UNited States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Pooock Augusta Whittle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Whitcomb / Son 505 Powell Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metroplitan Funeral Service 01/11/2008 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

Examiner Examiner

Physician/Medical

þ

Completed

Certification: To Be

Medical

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f show must be notified at

"natural", or items 23a

of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

by Funeral

Be

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Immediate Cause (Final disease or condition resulting in death) dostructive Chronic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTON Yes 2 No 3 Probably 4 Unknown 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√No Other:

A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran certifica After Director: within 24 hours aft

To the Funeral Di

completely filled in

Division or Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David J. Tardio, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Month

29d. Date signed (Month, Day, Year)

January 11, 2008

Year

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

DHMH 17 Rev 1/2001

08-00077 Carla Morgan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last)

Carla R. Willis Morgan 2. Date of Death 3. Time of Death Physician/ Month Day January 3, 2008 1735 hrs Medical Examiner Carla Rene Willis-Morgan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Howard Howard County General Hospital Columbia 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Director 183-52-0255 M 2 X F June 27 1960 CountryChester P Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location MD Howard Highland 1 X Yes 2 No or items 23a or 28a-f sho must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7408 Buckshaven Lane 20777 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2 X No Black. f Yes. Give Year 4 X Divorced Yes 2 X No specify: Specify Widowed Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.
t: If item 27 is marked other than "
other traumatic event, the Medical I MD 21215-0036 5+ Vice Principal School 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert Willis Jr. Mary F. Whittington

20b. Place of Disposition (Name of cemetery,

22. Name and Address of Facility

crematory or other place)

Chester Rural Cem.

nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart List only one cause on each line. Reactive airway changes complicated by acute and

Fetal death

Other (Specify)

Chronic bronchitis and rulmonary hypertension

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

01 - 12 - 08

Chester PA 19013

Approximate Interval

Between Onset and

Death

Year

DE 19803

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

death?

28f. Location (Street and Number or Rural Route Number, City

January 4, 2008

29d. Date signed (Month, Day, Year)

1 🗸 Yes

Day

Probably 4 🗸 Unknown

24b. Were autopsy findings available

prior to completion of cause of

2 No

Month

Yes 2 No 3

No

24a. Was an

autopsy

✓ Yes 2

Nursing Home 5 Residence 6

or Town, State)

performed?

28d. Describe how injury occurred

Chandler Funeral Home

924 W. 8th Street, Chester, PA 19013

2506 Concord Pike, Wilmington,

3 Ectopic pregnancy

26.Place of Death (Check only one)

Other₄

Yes 2 No

28c. Injury at Work?

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical xaminer

Baltimore,

ment (

19a. Informant's Name/Relationship (Type, Print)

1 X Burial 2 Cremation 3 X Removal from State

failure. List only one cause on each line.

(Mother)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Live birth

Unknown

28a. Date of Injury (Month, Day,Year)

(Specify)

and manner stated

32.

Assistant Medical Examiner

sistrar's Signature

9

Hospital: 1

Pending

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

23c. If yes, outcome of pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pregnant at time of death

AMENDED #23a,27,perME,g876, 2/28/08 TT

Inpatient 2 V ER/Outpatient 3

28b. Time of tniury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

5

Mary F. Willis

or condition resulting in death)

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the

25. Was case referred to medical

1 V Yes

27. Manner of Death

Accident

Suicide

Homicide

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Pay Year)

OCME

1 X Natural

Certification:

cal

State Registrar

2

3

filled in by the

1 Yes 2 No 9 🗸 Unknown

Sequentially list conditions. if any, leading to immediate

X UNPENDED

past 12 months?

IF FEMALE:

Donation 5 Other Specify: 21. Signature of Funeral Service Licensee CC!

20a, Method of Disposition

Examine and Physician/Medical attending physician a for use as the burial the detached signed by t be detache Completed by been certificate has After this

#1/Kast name

Hospital or Attending Physician: 24 hours after death. within 24 hours after death.

To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month Physician 7, A^{M} 5:40 January Dewey Robinson Brown-Bey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth
(Month, Day, Year)
April 30, 9. Birthplace (State or Foreign Country)
Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 1947 228-64-9693 60 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director Maryland | Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 U.S.A. 14625 Colonels Choice Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Building Construction Brick Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie E. Bumbray Joseph Henry Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Upper Marlboro, MD 20772 Randolph M. Brown (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If I
any injury or
once, Metropolitan Crematory 1/11/08 4 □ Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility
Joynes Funeral Home 21. Signature of Funeral Service Licenses P.O. Box 3633, Warrenton, VA 20188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** Acute disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? (es 24 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tres 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

JODELE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32 Registrar's Signature

7503 SURRATTS ROAD, CLIWTON, MARY LAND

29c. License number

D40324

29d. Date signed (Month, Day, Year)

JANUARY 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Busch Paul 15, 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Westminster 1435 Carroll Uniontown, Rd If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**凌**M 2□F 384-88-7448 July 14 1968 Michigan Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 21158 USA 1435 Uniontown Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Journeyman Plumber Plumbing 12 Pages 1 and 2 should be filed nent of Health and Mental Hygi int: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacklynn Joan Kesler William Busch ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1435 Joyce Busch Uniontown Rd wife Westminster, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry January 15,2008 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signalure of F neral Septice Licensee 7522 Connelley Drive Soite P. Hanover MD 21076 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Final CHOLINGIO CIRCINOMA **Physician** 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHOLANGITIS SCLEROSING PRIMARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has l autopsy this certificate 1□ Yes 2 100 Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 → 10 3□ D0A 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE BACT NSINGA UMMS 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7008 JAN

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 14, 2008 12:20 P.M Marie Young Bounds January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Longview Nursing Home Manchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 🛛 F 88 Sept.16, 1919 Virginia Director 220-32-3373 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 XNo Carrol1 **Eldersburg** Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 6603 Carroll Highlands Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medicine Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Robert N. Young Helen J. Hardy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is 6603 Carroll Highlands Road; Eldersburg, MD 21784 Patricia Lang Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Asnton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signatur - I uneral Service L 10/290 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilateral **Physician** /Medical Due to (or as a consequence of): Examiner therosclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 20 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 Yes 2 No Division or Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after dear 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 HOO6 1206 o use of d ath (Item 23a) (Type, Print) 30. Name and address of person who completed MANChester MD. HANOVER 22. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 = For State Registrar	State of I	Maryland / De <i>C</i>	partment of e <i>rtificate o</i>			Reg. No.	00870
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/sician ledical	Martha			1 41 On T	or Location of De	Jan 15	2008 4c. County of De	
aminer	4a. Fecility Name (If not institution, 11311 Ketter	-	er)					
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ctor		1□M 2∏F	92 Yrs.	Months Day	s Hours Mi	March 2	1915 Soi	th Carolina
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Director	10e. Street and Number	corge 5	1010	10f. Zip Code			10g. Citizen of What C	
erai Director	9510 Travers	se Way		2074	<i>L</i> i		United St	atos
Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S. 1	3. Was Decedent of		(Specify Yes or No erto Rican, etc.)	United St 14. Race - An Black, Wh	
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l Ho	Elementary/Secondary (0-12)	College (1-4	or 5+)	Nurse			Medica	.1
Be	17. Father's Name (First, Middle, L				18. Mother's N	lame (First, Middle	, Maiden Sumame)	
To B	John Lanha	m			Ida	Merriwea	ther	
	19a. Informant's Name/Relationsh		19b. M	ailing Address (Stre	et and Number or	Rural Route Numb	er, City or Town, State	Zip Code)
	Johnnie Kennedy	(Daughte	er) 9510	Travers	e Way, F	ort Washi	ngton, MD 20c. Location · City	20744
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from St						
	'4 □Donation 5 □Other (Sp		Marylan	d Nationa	1 Cemeto	22, 2008	Laurel, Ma	ryland
once.	21. Signature of Funeral Service L			22. Name and Add	I L	ee Funera	al Home, Inc	: 6633 Uld
	23a. Part 1. Enter the sur ase, or shock, sheart sture. List of	complications that cau	used the death. Do not	Alexandra	A Ferry	Rad Cl	inton, MD 2	0735 Poproximate
	shock, heart fure. List of Immediate ause that disease or condition			No.	2T A	Lupe		Interval Between Onset and Death
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Physician/Medical	IF FEMALE:	23c. If yes, outco	ome of pregnancy				23d. Date of o	delivery
cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt		3 ☐ Ectopic pregna 5 ☐ Other (specify,			Month	Day Year
nysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow						
leted by Pi	Part II. Other significant condition	ns contributing to dea	th but not resulting in th	e underlying cause	given in Part I.	23e. Did		to the cause of death?
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ို	1 ☐ Yes 2 ☐ No			HIBIT SEL DOA	erman re-	g Home 5 Res		Granddaughte Homo
on;	27. Manner of Death 1 Polynatural 5 Pending	28a. Date of (Month)	Injury 28b. Tim , Day Year) Inju		liury at Vork?	28d. Describe	how injury occurred	
Certification;	2 Accident investig	not be aga Blace o	of Injury - At home, farm		☐Yes 2☐No	28f Location	Street and Number or	Rural Route Number.
rtif	4 Homicide determine	ined 288. Flace of building	g, etc. (Specify)	Street, ractory, one	20	City or To	wn, State)	, rarar routo roundon,
20	29a, Certifier 1 Certifyin	g Physicien: To the b	est of my knowledge, d	eath occurred at the	time, date and pla	ace, and due to the	cause(s) and manner	as stated.
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dio	one)			29c. Lic	ense number		29d. Date signed (Mo	onth, Dey, Year)
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Medic	29b. Signature and title of certifier MMACLASS			1	16619		JANUARY	16, 2008
Medical Cerl		and no	of death (Item 23a) (Ty					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Year Month **Physician** 01 30 AM MAT 2008 il Catherine M. Bass /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Agnes Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ■ M 2 3 F Director 220-48-4078 90 2/12/17 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö USA items 23a Funeral 21228 6626 Altamont Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MarNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Completed by Specify: Specify 3 Widowed 4 ☐ Divorced White "natural", er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumafic event, the once. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Anthony F. Scholtholt 2 Catherine M. Dieter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Scholtholt 4218 Kensington Rd. Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemeterv 1/14/08 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lie Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part1. Enter the disease, or emplications that caused the shock, or wart failure. Live any one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis day /Medical Due to (or as a consequence of): Examiner ARF 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CHF or Attending Physician: The law requires that the death certificate be executed years Due to (or as a consequence of): P.O. Box 68760 HTN Vear S Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1□ Yes 2☑No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🕱 No 2 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD alchan, 2008 P: 20655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD. MOHAMMAD VALIKHANI 900 AVE 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / [Department Certificate	t of Heal	lth and Me <i>ath</i>	ntal Hygier		00872
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	Examir Funeral	ner	4a. Facility Name (If not institution, give stre	7. Age (In yrs. last bin	thday) If Under	Value If U	ation of Death Jinder 24 Hrs. 8 Durs Min. 8	Date of Birth	4c. County of De	rthplace (State or Foreign
	Director Mou		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	Yrs.	Owings		Jul 16,7193	11 N	10d. Inside City Limits
	with the Ma e or 28a-f s be notified	Director	Maryland Baltimore 10e. Street and Number 19 White Willow Court		10f. Zip	Code	1117	10g.	Citizen of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other traumatic event, I'm Medical Enain and must be notified at ance.	Completed by Funeral	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Deced If Yes, spec	Y	nic Origin? (Speci exican, Puerto Ri pecify:	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	within 72 ho jiene. r then "natur r Medical	ompleted	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	con 16a. Coilege (1-4or 5+)	Decedent's Usua (Give kind of wor life. DO NOT us	k done during	g most of working	16b.	Kind of Busines Baltimore	
yland;	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Dorsey Let	wis		18. I	Mother's Name (First, Middle, Maid Delena		
e, Mar	t and 2 sho tealth and om 27 is ma		19a. Informant's Name/Relationship (Type, Ivory Lewis		Mailing Address 19 White V Disposition (Name	Villow Co	Number or Rural R urt Owings	Route Number, Cit Mills, Marylar	y or Town, State, dd 21117 Location - City of	
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Ba	permi Depa Impo any ir	I	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death. Do n	130	0 Eutaw	Place Baltin	Service, P. A. nore, Md 212 espiratory arrest,	17	Approximate Interval Between
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8760,	death certificate be executed X a set a se	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	Jr): 1 (Teny	0190	> > €		
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Vital Records,	The larate has	Completed by	Ridney FAIL	cllifus				24a. Was an autopsy performed 1 Yes 2	prior to death?	
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Divis	spitel or Attending P ours after death. Incel Director: After I filled in by the funera	Certification;	2 Cuiside 6 Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory	, office	28	f. Location (Street City or Town, St		Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only 2 Medicel Exeminer one)	en: To the best of my knowledge : On the basis of examination and and manner stated.	d/or investigation,	in my opinion	n, death occurred	at the time, date a	and place, and du	e to the cause(s)
n -	S with	~	29b. Signature and title of certifier	W 7x8, 5	00 1	License num	78	~	Date signed (Mor	
	1		1.	leted cause of death (Item 23a) (Type, Print) + Ruad	Roma	dalls fo	ny W	i) ¿	10,2008
	Sta Registr		IAN 1 7 2000	SZ. Hogisti at a digitatura	14 - J. B.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month PM Royal R. Carsten, Jr. 14, 2008 January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death N/A Home; 3300 Elm Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Days Hours Months Min. 1**/2** M 2 □ F 54 220-62-3504 08-04-1953 Kansas Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County XXYes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 3300 Elm Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes → No If Yes, Give 1 ☐ Yes 2/CM/No Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Windshield Installer Smith Auto & Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Nunn Royal R. Carsten, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 Elm Avenue Baltimore, Maryland 21211 Virginia Carsten Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road Baltimore, MD 21211 21. Signature of uneral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARCINOMA ZYEARS 6811 SHIAMONS Due to or as a consequence of) LOBACCO Sequer tielly list on citic is if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
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Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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"natural", or

I Hygiene.

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event. the

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funeral director, After

Physician/Medical Completed by Be Certification: To

Medical

Examiner

The or Attending Physician: death within 24 hours after death

To the Funeral Director:
completely filled in by the

Vital

o

Division

Hospital

State Registrar 29b. Signature and title of certiflet

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

VARK

ELVA 31. Date filed (Month, Day, Year)

determined

4 Homicide

(Check only one)

29a, Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year ROBERT STEWART 02:30 A M COHEN JANUARY 14 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OF N/A HOSPITAL BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/25/1941 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 X M 2 □ F 212-38-1483 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1 X Yes 2 □ No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3021 FALLSTAFF ROAD, #406 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GENERAL MANAGER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRY COHEN IDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HARRIET COHEN / WIFE 7121 PARK HEIGHTS AVE., #801 BALTIMORE, MD 21215 20b. Place of Disposition (Name of ARL CENTY ON THE Place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 01/16/2008 BALTIMORE, MD AMUNO CONG. 4 □ Donation 5 □ Other (Specify) 21. Sign the Juneral Service Lize 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one code on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYNDROME RESPIRATORY 2 WEEKS DISTRESS disease or condition resulting in death) ACUTE Due to (or as a consequence of): SEPTICEMIA 2 WEEKS NE GATIVE Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes DEPENDENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No KETOACIDOSIS 24a. Was an DIABETIC autopsy ormed7 2 ⊠No APNEA 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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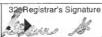
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Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 TVes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ ALCOHOL Completed HYPEROSMOLAR OBSTRUCTIVE SLEEP Be 25. Was case referred to medical examiner? 1 ☐ Yes P 27. Mann of Death Certification: 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 14 2008 MD RES - 000

State Registrar

31. Date filed (Month, Day, Year)

SENGUPTA



2401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE

MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Director		217 < 22-5951 45 Yrs.	JULY 12	1912 NC
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any injury or other treumatic event, the Medical Exterior must be routiled at once.		Controllery, Crematory of Other place)		
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on	Jing After fune	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	od. Describe now	injury occurred
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		Me	29b. Signature and title of certifier Solution 30. Name and address of person who completed cause of death-filter 23a) (Type, Print) Rand Sancepal No. 200-109 / Sack Riv 31. Date filed (Month, Day, Year) 32. Registrar's Signature	290	d. Date signed (Menth, Day, Year) 2008
	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ranch Sahapathu 201-109 /SackRiv	red NECK	k Road Baltimore mayor dist.
	Sta Registi		31. Date filed (Month, Day, Year) 32. Aegistrar's Signature		V

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 5:00A. M 4c. County of Death Carroll Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 □Yes 2√Wo 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry US Postal Service Westminster, MD 21157 20c. Location - City or Town, State 2008 Winfield, MD Approximate Interval Between Onset and Death Year 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Inhancement 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) lancheste RI Mancheste

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Registrar

29a. Certifier

29b. Signature and title

31. Date filed (Month, Day,

Medical

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29c. License number

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Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	7229 Graces (uarters R	oad		10f. Zip Code 21027				USA	en of Wh	at Countr	y?
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	21. Signature of Funeral Service Christina Rol	Licensee	ur		Name and Addr					ral	Home	of Essex
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Division of Vital Records, P.O. Box 68760, To the Ilospital or Attending Physician: The law requires that the death certificate be executed writhin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) 2 Medical Exa	aminer: On the basis and manners	of examination.	and/or investiga	ition, in my opin	ion, death o	ccurred at the	e time, dat	e and pla	ce, and d	ue to the	cause(s)
F 3 E 8	N N	29b. Signature and title of certify		//			ense number	г					h, Day,Year)
(2)				Mo		0.0	C.M.E.			Jani	uary 11	, 2008	
		 Name and add of persons Mary G. Pupple MD. 	who completed and Deputy Chier			1 Penn Stre	et, Baltim	nore, MD 2	21201				
Si	ate	31. Date filed (Manth, Day, Year)	97	egistrar's Signa		20		·					

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Certificate of Death
Reg. No. 1 - For State Registrar Reg. No.2 0 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** vernon HOLLY 1535 05 2000 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns HOPKINS HOSPITAL Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 **№** 2 🗆 F Days Hours 3-1959 Director 400y/and Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at 1 XYes 2 No **Funeral Director** MD 1 timore 10g. Citizen of What Country? Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO not use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) road 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau Pages 1 and 2 Mother. hristine HO/12 170.MD 21105 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01363 K 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain inlun anoxic Physician 3 days /Medical Due to (or as a consequence of): Examiner metabolic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) **Pancreatitis** 3 weeks burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 nknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes MInpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , Medical Doctor RES-000 January 05, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hansie Mathelier, The Johns Hopkins Hospital, 600 North Wafe Street, Balthmore MD 21287 Hansic Mathelier, The

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles L. Harris 2008 6:45 P M 14, January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Home; 1323 Park Avenue N/A Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 216-14-1685 84 Director 6-15-1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1323 Park Avenue 21217 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 No Specify. by Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Park School & MD Elementary/Secondary (0-12) College (1-4or 5+) Institute of Art Artist & Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles L. Harris Gladys Evelyn Derry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Harris Wife 1323 Park Avenue Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ★★ Cremation 3 ☐ Removal from State Metro Crematory 1/16/2008 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 7 Funeral Service Livenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Part Enter the disease, or com shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final ARTERY DISTASE RONARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a conséquence of): Examiner death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of)

Physician /Medical Examiner

Box 68760

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or Vital Records,

Completed by Physician/Medical signed I this certific ral director, Be Certification: To

has

certificate

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral

or Attending

To the Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

29a, Certifier

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9□Unknowr

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLIAVS

HYPERTENSION

MACULAR DEGENERATION 25. Was case referred to medical examiner?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

autopsy

29c. License number 1)45 244 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

RAJA", GREENE ST, BALTIMORE, MD-21201 CHANDRAKALA 10 N.

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		rtment of H tificate of L			giene Reg. No. 20	08	00880
	Physicia	an	1. Decedent's Name (First, Middle, La	*					2. Date of De	Day	Year	3. Time of Death
	/Medic	cal	Mary Agnes Hamme 4a. Facility Name (If not institution, giv		r)		4h City Town or	Location of Death		4c, County o	008	10:50 AM
	Examin	ier	Charlestown	o sireer and namber	/		Catons			,	timo	re
	Funeral Director		5. Social Security Number 225-10-0320 6. S	ex 7. A	oge (In yrs. Ia 90	**	If Under 1 Year Months Days		8. Date of Birt (Month, Da Dec. 1	h	9. Birthp	lace (State or Foreign
	and t		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	Maryl t-f sho fied a	tor	Maryland Balti	more		Catons	ville					1 ☐ Yes 2 🖾 No
	or 28g	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	s 23a nust b	eral I	707 Maiden Choice			140.11	2122			USA	Amorio	an Indian.
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? No	l II	Vas Decedent of Hi i Yes, specify Cuba ☐ Yes 2☑ No	spanic Origin? (S) in, Mexican, Puerto Specify:	o Rican, etc.)		, White,	
0-017	ithin 72 ho ne. nan "natur a Medical I	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)	(Give I life. D	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wor)		16b. Kind of Bus		
7	filed w Hygier ther th		1.2 17. Father's Name (<i>First, Middle, Last</i>)		Adm	inistrati 			Federal Maiden Surname		ernment
<u>0</u>	lid be lental liked o	To Be	William Weller						Kenned		-7	
<u>a</u>	2 shou and M is mar		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numb	er, City or Town, S	State, Zip	Code)
(1)	l and 2 lealth m 27 her tr		E. Diane Steele 20a. Method of Disposition	Daugh			Steeplech	ase Way,	Southe	rn Pines		
5	ages int of H		1 ☐ Burial 2 ☐ Cremation 3 ☐		e ce	metery, cren	natory or other place ematory				,	Maryland
	artme ortan injun		4 □ Donation 5 □ Other (Special 21. Signature → eral Service □ Control		1100	22	Name and Address	ss of FacilitySte	rling A	shton Sc		
ŏ	permit Depar Impor any ir		1Cy/	/		$- \begin{vmatrix} \mathbf{F}_1 \\ 1 \end{vmatrix}$	uneral Ho 630 Edmor	ome of Ca ndson Ave	tonsvil nue: Ca	le, Inc. tonsvill	e, M	D 21228
	hysician '		23a. Part1. Enter the disease, or com shock, or heart fature. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	ed the death. line.							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):						
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ	ence of):						
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0/00,	ificate be executed this physician an the burial-transing the burial-transition the burial-transition the burial-transition the burial-transition the burial-transiti	alEx	resulting in death) Last	Due to (or a	s a conseque	ence of):						
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.O. DOX	siclan: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
orus, r	quires that in signed b uld be deta	by P	Part II. Other significant conditions	contributing to death	but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did t		bute to th	ne cause of death?
ם מיני	The law recate has been page 2 sho	Completed							24a. Was autor perfo 1 Yes	osy pormed? de	/ere auto rior to cor eath? □ Yes	psy findings available mpletion of cause of
V 11.0	siclan: certific rector,	ag .	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Dea				
5	g Phys er this eral dir	.: To	1 Yes 2 1No 27. Manner of Death	28a. Date of In	jury	R/Outpatient 28b. Time of	28c. Injury	Nursing H		dence 6 Othe		y)
5	ath. or; Afte	atior	1 Natural 5 Pending investigation		ay Year)	Injury		<br Yes 2 ☐ No				
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Flace of I	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	eet, factory, office		28f. Location (S City or Tou	Street and Number vn, State)	r or Rura	al Route Number,
	the Hosp in 24 hou the Funer ppletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example Medical Ex	nysician: To the best niner: On the basis and manner:	of examinati	vledge, death ion and/or inv	estigation, in my o	pinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as s ind due to	tated. o the cause(s)
	with Con	2	29b. Signature and title of certifier	mn			29c. License	number		29d. Date signed		Day, Year)
	15		30. Name and address of person who	711	Mad	- Che	1 m	Calins	1:14	Mer	1	
	Sta Registr		31. Date filed (Month, Day, Year)	No.	strar's Signati	ure	U					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 13, 2008 4:15p JANUARY /Medical REGINA HARLAND 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE N/A Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 9-4-1949 MARYLAND 213-54-3806 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1X Yes 2 □ No Director BALTIMORE RANDALLSTOWN MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8349 STREAMWOOD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 P No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the NURSING HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F 7 is marked ott EMMANUEL McCRAY HENNRIETTA HOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health of Important: If Item 27 is any injury or other tra JOANNE CARPENTER (SISTER) 844 CARBERRY LANE BALTIMORE, MARYLAND 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation B ☐Removal from State MT. ZION CEMETERY 1-19-2008 BALTIMORE, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signatur Service Licensee JONATHAM D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Vusue 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Parti. Enter the dis shock or heart fail Immediale Cause (Final disease or condition resulting in death) ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ung cancer years /Medical Due to (ir is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician Reginal Har land 1/13/c Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Z Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specific Control of the 2 No 2 1 TYes this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death.

I Director: After to in by the funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ь To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1/5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

SOM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospic Signature

838 NEutaust Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 14, 2008 Florance V. Hooper 8:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-03-9916 1 M 2 ₩ F oct 10, 1915 92 Delaware Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Cockeysville 1 □Yes Ž□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 York Road Apt 141 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2☐ No f Yes, Give _{Specify:}White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Freeman Eleanor Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat 4503 Rehbaum Avenue Halethorpe, MD 21227 Jennifer Hastings- Grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Fuheral Service Licensee 23a. Part 1. Enter the divel sever complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on pactrine. Immediate Ouse (Final disease or condition a. 6224 Eastern Avenue Baltimore, MD 21224 Physician /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 40 Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. r significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? Be Completed by 162/70 mileo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

FLORANCE HOOPER

with the Maryland

death v

7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at

a filed within 72 hours after do Il Hygiene.

other than "natural", or Item

Baltimore, Maryland 21215-0036

2 should be and Mental

2007

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IANUARY

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760 as ed by the a page 2 s or Attending Physician; After this (Certification: To eral Director: A filled in by the fu 4 ☐ Homicide urs af 29a, Certifier Medical

To the Hosi within 24 ho To the Fund completely f
24

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA

(Check only one)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature

★ Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or invegand manner stated.	occurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated. ne, date and place, and due to the cause(s
ittle of certifier	29c. License number	29d. Date signed (Month, Day, Year)

1 1550k

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:33 A.M ĪŚ, 2008 January Steven Glen Knatz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Carroll Hospital Center Westminster 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Aug. 12, 7. Age (In yrs. last birthday) 5. Social Security Number , 19<u>54</u> **Funeral** Days Hours XM 2□F 53 Yrs. Aug. Director 217-48-6559 Usual Residence of Decedent 10d. Inside City Limits Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be nutilied at 1XXYes 2 □ No Directo PA Hanover York the 10g Citizen of What Country? United States 10f. Zip Code 10e. Street and Number õ 17331 4072 Grandview Road permit. Pages 1 and 2 should be fited within 72 hours after death a Department of Health and Mantal Hygiene. If them 27 is marked other then "neturel", or Items 23e eny injury or other traumatic event. If a Maintest Education 2000. America Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 20XNo Specify: Specify: White 3 Widowed WDivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sawyer Building 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Rote Philip Knatz, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4072 Grandview Road, Hanover, Pennsylvania 17331 (Fiancee) Laurie Miller Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Jan. 19, Greenmount United 3 Removal from State MXBurial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) Greenmount, Maryland Methodist Ch. Cem. 2008 Si mature / Fun Al Si nyice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached the 9□ Unknown 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 □ Yes 2 □ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WV) lerron Sr. 32. Registrar's Signature 31. Date filed (Month, Day, 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #29d, perMD, 2875, 1/17/08 TT Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY ΪŐ 2008 SYLVIA **ESTHER** KLEIN 1:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8415 BELLONA AVENUE. TOWSON APT. 517 BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 X F Months Days Hours 216-05-6824 89 Director 08/31/1918 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD BALTIMORE TOWSON 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8415 BELLONA AVENUE, APT. 517 21204 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **MEYER** RECHTMAN anna YEAGER ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN LORCH / DAUGHTER 1 HIGH PASTURE COURT, OWINGS MILLS, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 01/13/2008 REISTERSTOWN, MD 5 ☐ Other (Specify) 21. Sign 1 22. Name and Address of Facility Funeral Service Logna SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eurs /Medical Due to (or as a conseq Examiner elle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months?
1☐ Yes 2☐No
9☐Unknown Day Month Year 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown nine Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1□ Yes 2 No cate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Completely filled it 1 🗶 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0008093 Magnente 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

MArguerite T. Moran, MD

31. Date filed (Month, Day, Year)

2346

32/Registrar's Signature

A SARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Marie Jan 8,2008 11:22 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Md Hospital Clinton
If Under 1 Year If Under 24 Hrs. | Prince George 7. Age (In yrs. last birthday) 8. Date of Birth State or Foreign **Funeral** Days Hours 523-22-3596 Feb 22, 1928 1**x** x 2 □ F 79 Director New Mexico Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Prince George Clinton 1 ☐ Yes 2 K No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8805 Old Branch Ave 20735 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 →Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. Native American Saltimore, Maryland 21215-0036 ğ 3 ☐ Widowed 4 ☐ Divorced Viotnam

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) American Indian 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Air Force Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter M Montoy Anastasia Maestas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sanchez 315 Cresdone Ave Salida Colorado 81201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee Crematory Jan 16, 2008 Clinton, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ► No 24a Was an 1□ Yes Division or Vital 25. Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 01,08,2008 DO0 62200 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

841

Amit Suri, MD
State 31. Date filed (Month, Day, Year)

7503 Surratts Road, Clinton, MD

2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav Year **Physician** 25 DM 200 8 /Medical ames 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner timor Universi 5. Social Security Number 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 ₩ 2 F Director 218-42-5197 63 Aug 3, 1944 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show ns 23a or 28a-f sh must be notified 1 ☐ Yes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2308 Tioga Parkway 21215 U.S.A. Completed by Funeral death item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes 2 □ Nyo Specify Specify: Black 3 ☐ Widowed 4 ☐ Brivorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterfront Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine McPhaul Neil McPhaul မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Gilmor Street Baltimore, Maryland 21217 Sheila Fisher 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/14/08 Catonsville, Maryland Metro Crematory, Inc. **U**uneral 22. Name and Address of Facility 21. Signature Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** rostate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician the attending phene as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Wnknown 2 No 3 Probably 1 TYes

Completed by page 2 should be has been certificate funeral director. Be ဥ After this Certification: ial or Attendis after death.
Il Director: A filled

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠ No 24a. Was an autopsy perform 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Aocident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital o within 24 hours aff To the Funeral D State Registrar

Medical

Attending Physician:

29b. Signature and title of certifler

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

DG.

DEA: AU4176435B1812

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beckman MD Dawn

31. Date filed (Month, Day, Year)

(Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				of Maryland /	Depa		Health an	•		2002	008	87
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	/Medio Examin		4a. Facility Name (If not institution, give street and PG Community Hospit	number)		4b. City, Town, Chever	ly		4c. C	County of Death	1330	
	Funeral Director		5 Social Security Number 6. Sex 1 1 M 2 □ Usual Residence of Decedent	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, E 0 9 - 1 5	irth Day, Year) 5 – 194	9. Birth Cou 8 Wash	place (State or Fintry) DC	oreign
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	th with the 23a or 28a ust be not	al Director	10e Street and Number 5222 56th Ave.			10f. Zip Code 2073	37		10g. Citize	en of What Cou USA	ntry?	
980	d within 72 hours after death with the Maryland glen. Jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner.	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? es 2X No , Give or Dates:	1	Was Decedent of f Yes, specify Cul I ☐ Yes 2☐ X No		? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: Bla	etc.	
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, Mar	permit. Pages 1 and 2 should by Department of Health and Mentis Important: If Item 27 is marked any Injury or other traumatic enone.		19a. Informant's Name/Relationship (Type. Print Eddie L. Neal/ Moth	er 5	48 1	Peabody		or Rural Route Nurr NW Washi	ngto	n DC 2	0011	
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Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee)—	10	08 W. N	orth A	Ronald T Ave. Bal	timo		21201	
r	Physician /Medical Examiner		Du Du	Mat caused the death. Do on each line. al Cardia e to (or as a consequence	c Ai			rdiac or respiratory	arrest,		Approximate Interval Betwe Onset and Dea Minutes	ath
1760, ★	ate be executed nysician and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events c.	e to (or as a consequence								
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Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	I ☐ Inpatient 次 □ ER/0	Outnation	t 3 DOA Ot	hor	Death Check onling Home 5 Re			26.3	
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r.	\ \ \ \	M	29b. Signature and title of certifier	as mi	D		se number 3411			signed (Month		
U)]		30. Name and address of person who completed J. Shesadri 14300	Gallant I	ox	Ln. #2	10 Bow	ie, MD	20715			
	Sta Registr		31. Date filed (Month, Day, Year)	22 Registrar's Signature	A STATE OF THE PARTY OF THE PAR	nde)						

08-00305	
Rafael Peay	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

afael Peay		State of Maryland / Department of Certificate of I		-	a No. 200	8 0088
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	h	3. Time of Death
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		4a. Facility Name (if not institution, give street and number) 4b 604 North Curley Street	o. City, Town, or Location of Deatl Baltimore	1	4c. County of Death N / A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY) 9. Birtl	place (State or
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Baltimo per it. Page De artment o Important: injury or oth			me and Address of Facility	Funer	al Service	D DΔ
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Physician // // // // // // // // // // // // //		23a. Part I. Ent., the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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Rec The I	히			1 🗸 Yes		s 2 No
ital sician: s certi	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other 4 Nursi		Residence 6 V Other	
Division of Vital Records, tal or Attending Physician: The law require is after death. In Director: After this certificate has been sided in by the funeral director, page 2 should be	임	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)			now injury occurred	Scene
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:15 AM Jan Gerard Schaafsma 14 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2905 Overland Avenue Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9 562-03-7747 November 15, 1910 Director Hawaii Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Overland Avenue USA 2905 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5 + Elementary/Secondary (0-12) Chemical Engineer OIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everdine Gratama Schaafsma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathryn Schaafsma/Daughter 2915 Overland Avenue Battimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Anatomy Gifts Registry JANUAR 14, 2008 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anothery Gifts Registry 21. Signature of Funera 7522 Connelley Drive Suite P. Hanover, MB 21076 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA SENILE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARG9 OBSTRUCT ION 2 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 No 1 Tyes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 51715

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh p8/6 2-4-08 vt. State of Maryland PDepartment of Health and Mental Hygiene () () ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 1150 PINM Mae Belle Stanley 2005 J. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF 91 Yrs. Director 577-24-9034 04/06/1916 S.C. Usual Residence of Decedent with the Maryland **⊕**how 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f eho other traumatic event, the Madical Examinar must be notified at Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Randolph Place NW 20002 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or item any injury or other traumatic event, the Medical and once. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Miles Joseph Lizzie Springs 2 19a. Informant's Name/Relationship (Type, Print)
Niece
Mary Smallwood/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Randolph Pl.NW Washington, DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2008 Arlington, VA Arlington Cem. 22. Name and Address of FacilityRonald Taylor II Funeral Hm. 21. Signature of Funeral Service Licensee 108 W.N. Avenue Baltimore, MD 21201 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ansnolosenter accident. /Medical Due to (or as a consequence of): Examiner Cardio voiseules disease. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit portipidem Due to (or as a consequence of) Box 68760 attending physician I for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. cete has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 2 No amand 1 Yes 2 No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA his funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number sorpho completed cause of death (Item 23a) (Type, Print) 4701 Randolph Rd #Zil Rockville MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State

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amend item 10e per fh, 8875 1-24-08 vt.

		•	1- State of Maryland / Bepartment of Health and Mental Hyglene Certificate of Death Reg. No. 2 1 8 9 3
	es 1 and 2 should be filed within 72 hours after death vor Heath and Mental Hygiene. I them 27 is marked other than "natural", or Items 23ar other traumatic event, the Medical Examiner must	an	1. Decedent's Name (First, Middle, Last) Maurice W. Street Jr. 2. Date of Death Month Jan. 14 Day 2008 12:57 pm
No.		_	4a Facility Name (If not institution, give street and number) Southern MD Hospital 4b. City, Town, or Location of Death Clinton 4c. County of Death PG
₩.			5. Social Security Number 578 - 68 - 6941 120 M 2 F 7. Age (In yrs. last birthday) Funder 1 Year If Under 1 Year If Under 24 Hrs. Days Hours Min. Days Hours Min. D4 (Months Day) 9. Birthplace (State or Foreign Country) Wash. DC
land 21215-0036		Funera	Usual Residence of Decedent 10a. State MD 10b. County PG 10c. City, Town or Location Suitland 10d. Inside City Limits 1 Yes 2 No
			10e 20746 10g. Citizen of What Country? USA
			11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 ☐ No Specify: 16. Yes 2 ☐ No Specify: 17. Yes 2 ☐ No Specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Armed Forces? 10. Yes 2 ☐ No Specify: 11. Yes 2 ☐ No Specify: 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)
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		To Be Co	17. Father's Name (First, Middle, Last) Maurice W. Street Sr. 18. Mother's Name (First, Middle, Maiden Surname) Mary Jackson
Maryland			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Lucente Ave. Suitland, MD 20746
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Riverdale PK Crem. 1-16-08 20c. Location - City or Town, State Riverdale, MD
Balti	permit. Pag Department Important: If any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facili Ronald Taylor II FH 108 W. North Ave. Baltimore, MD 21201
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Approximate Interval Between Onset and Death Onset and Death
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68760,		To Be Completed by Physician/Medical Exa	that initiated events resulting in death) Last Due to (or as a consequence of): d
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Vita			25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify)
on or			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred
Division		Medical Certification:	2 Accident 3 Suicide 4 Homicide Accident
			29a. Certifier (Check only one) 29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	\		
	\	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC MCDonal DMD 7503 SURRALLS RD Clinton, md 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
54)	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 7 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year PM ROBERT TUCKER TANUARY 1315 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL NORTHWEST RANDALLITOUN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 2 V 2 □ F New York Yrs. Jan 8, 1924 84 087-14-8316 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Nes 2 No **Baltimore Baltimore** Maryland 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 3233 Carlswood Circle 21244 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1943 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Rex Company College (1-4or 5+) Administrator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary A. Tucker Arthur L. Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3233 Carlswood Circle Baltimore, Maryland 21244 Frances Tucker Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 ☐Removal from State 01/18/08 Owings Mills, Md. Garrison Forest Veterans Cemetery 4 Donation 5 DOther (Specify) 21. Signature of Funeral Jeruce Lice see 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic merkle Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Close ase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evonce.

l and 2 should be fi lealth and Mental F

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

and attending physician the as asn ed by the a signed by t d be detach has this certificate After

The law requires that the death certificate be executed

the Hospital or Attending Physician:

To the Hospital within 24 hours a To the Funeral C

filled in by the

Division or Vital Records, P.O. Box 68760,

Physi	9☐ Unknown	9□Unknown		1-F//		
by	Part II. Other significant conditions		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow			
Completed					24a. Was an autopsy performed? 1 Yes 2 ☑Wo	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☒ No
Be	25. Was case referred to medical	26. Place of Death (Check only one)				
10	examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) n	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Certification	3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fac	tory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1 Medical Example	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
š	20h Signature and title of certifier			29c License number	29d Date	e signed (Month Day Vear)

29c. License number

20059736

HOSPITAL

NURTHWEST

29d. Date signed (Month, Day, Year)

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State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 3 1 3 mg

TTER ATRICA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00279 State of Maryland / Department of Health and Mental Hygiene Tommy Thomas Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Dav Physician/ 1141 hrs **THOMAS** EDWIN January 10, 2008 TOMMIE Mederal Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 06/15/1946 Country) MS Director 426-88-3581 1 X M 2 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 X No ARROLL Anne Arundel HANOVER MD items 23a or 28a-f show ust be notified at once Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number USA 21076 7743 SIDEN DRIVE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 1 Never Married 1 X Yes WHITE Yes 2 X No specify: Specify 4 X Divorced If Yes, Give Year or Dates: "natural", 16b. Kind of Business/Industry ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) OFFICE SUPPLIES PROPRIETOR and Mental Hygiene. 27 is marked other than the Medical 4 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KIRKFIELD **THOMAS** BEATRICE EDNA **EDWARD** W. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) SPRING GROVE, PA 17362 236 COURTNEY COURT S S DAPHNA THOMAS MORGAN / DAUGHTER ges and at of Health a st. If item 2' r other traur 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State crematory or other place) 01/15/2008 TOWSON, MD HILLTOP SERVICE CORP. permit. Page Department of Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death o fica a. Multiple Injuries Immediate Cause (Final disease iminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit sician/Medical AMENDED #1, perME, g875, #10b.perFH.g875, 1/17 ./31/08 TT UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 V No 3 Probably 4 Unknown ρ ے 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, prior to completion of cause of peen autopsy performed? death? has No 2 ✓ Yes 2 No 1 🗸 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Be Nursing Home 5 Residence 6 Hospital: 1 Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes ို 28d Describe how injury occurred 28a. Date of Injury (Month Day Year) Jan 10, 2008 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Driver auto fixed object collision After ö 1055 hrs 1 Yes 2 ✔ No Natural 1 Pending 24 hours after death. in by the Director: Certificati 28f. Location (Street and Number or Rural Route Number, City 2 🗹 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 7677 Ridge Chapel Road, Hanover , Md. 3 Could not be Suicide determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Winder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

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State Registrar

29b. Signature and title of certifier

Mary G. Kipple MD.

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 11, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day HELEN MADELINE VACOVSKY 15, 10:30A^M JANUARY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7921 ROSELAND AVENUE ROSEDALE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 219-30-3793 72 10-26-1935 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7921 ROSELAND AVENUE 21237 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FLOOR LADY SUBURBAN PLASTICS 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN CALO UNKNOWN (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE VACOVSKY/SON 7921 ROSELAND AVE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) ENIONEMENT CARDENS OF FAITH CEMETERY 1-18-2008 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ea/2 Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

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Department of Health Important: If item 27 any injury or other the

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

sician and The law requires that the death certificate be executed for use a ed by the a signed by page 2 Hospital or Attending Physician: this funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a, 25 per dr. 63875301/1/7/198dhb Reg. No. 2 U 0 8 0089 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** Franklin Welch 5:30 AM M January 1, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Sept 1, 1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) **Funeral** Days unk 69 214-36-3493 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at Director 1 ☐ Yes 2 ☑ No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 7051 Carroll Avenue #1017 20912 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U ank Armed Forces? 11 Marital Status unk Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical filed within Elementary/Secondary (0-12) College (1-4or 5+) marked other unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth other traumatic even Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation permit. Page Department o Important: If any injury or = 5 3 Removal from State 4□Donation 5₩Other (Specify) in state 21. Si nature of Funeral Surviv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician on austri /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of) 68760 physician the use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 ☐ Unknown à ۵. requires that ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1 Division or Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Year) (Month, Day 1 HNatural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No the 1 after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I Hospital 1 Secritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

Baltimore. Maryland 21215-0036

Division or Vital Records. P.O. Box 68760.

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		Registrar	- /Fi - 4 - 8 41 - 1.1/-	141		Ce	ertificate of	Death	2. Date of De	Reg. No.	Ш8	3. Time of Death		
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/Med		4a. Facility Name //	f not institution.	give street and number		is vva		or Location of Death	1	Jan 13, 2	ty of Death	<u> </u>		
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y a	မ			nan W. Harris		T				Lena Paig				
15, INION YIGHTO Z 12.15-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's N		ip (Type. Print)				et and Number or Ru don Street Bal		· ·		ip Code)		
1 and Healt Healt Sem 2			eborah Garrett 938 North Eden Street Baltimore, Maryland 21205 lethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To											
permit. Pages 1 and 2.9 Department of Health at Important: If item 27 is any Injury or other trauones.			☐Cremation		Baltimo	ore. Md.								
permit. F Departm Importar any Injur			4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery & Chapel 01/19/08 Signature of Funeral Service Ligensee 22. Name and Address of Facility											
Deparing Department of the conce.		1/20	22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217											
		23a. Part1. Enter	he disease, or o	complications that cause only one cause on each	d the deat	h. Do not ei	nter the mode of d	ying, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between		
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/Medical Examiner		resulting in death)		Due to (or a	s a conseq	uence of):	-							
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ath ce	ian/	23b. Was deceder in the past 12		23c. If yes, outcom	2 Feta	l death 3	□Ectopic pregnar				Date of deli Month	very Day Year		
the de	Physician/Medica	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□Unknown	at time of d	leath 5	Other (specify)							
that seed by deta		Part II. Other signi	ficant conditio	ns contributing to death	but not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?		
quire;	ed by		Bo war	any hyper of	EN211				10	Yes 2 No	3 □ Pr	obably 4 □Unknown		
law re	plet		hyper	(Soepedas)	em)	>			24a. Was		b. Were au	topsy findings available completion of cause of		
The ate has page	Completed		M						perfe Yes	ormed?	death?	V		
clan: ertific	Be (25. Was case reference examiner?		11			21	26. Place of Dea	ath (Check only	one)				
Physl this o	은	1 Yes 2		Hospital: 1 Inpat		ER/Outpation	elle OKTOON		lome 5 Res	idence 6 🗆 0		cify)		
ding h. After fune	tion	1 Natural												
Atten r deat ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ot be 28e. Place of in	njury - At ho	ome, farm, s	street, factory, offic	ce			mber or Ru	ıral Route Number,		
tal or safter al Dir	Certification:	4 Homicide		building, e	nc. (Speci	у/			City or 10	wn, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	g Physiclan: To the bes Examiner: On the basis and manners	of examina	owledge, dea ation and/or	ath occurred at the investigation, in m	e time, date and place by opinion, death occ	e, and due to the urred at the time	e cause(s) and , date and plac	manner as e, and due	s stated. to the cause(s)		
To th within To th сотр	Me	29b. Signature and	title of certifier	11 /	-			ense number		29d. Date sig	ned (Monti	h, Day, Year)		
		> \	1 X	11 8 W.C	}		103	4)46		1115	200	8		
21		30. Name and add	ress of person v	who completed cause of	death (Iten	n 23a) (Type	Print)	Blower	Manjo	ml 21	213	3		
Si * Regis	tate	31. Date filed (Mon	nth, Day, Year)	32. Regis	trar's Signa	ature	A SEP							
T negis	arai	JA	MAT (,	A Happy Street		-								

Physician /Medical Examiner Examine certificate be executed

Physician

/Medical

Examiner

10a, State

MD.

Funeral

Director

r 28a-f show notified at

'natural", or items 23a or dical Examiner must be

the Medical

within 72 hours after

12 should be filed within hand Mental Hygiene.
7 is marked other than "

permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

physician and s the burial-trans Physician/Medical use as the signed by I Completed page 2 certificate or Attending Physician: After thi funeral death. the Funeral Director: npletely filled in by the

Pa

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Be 2

Certification:

Medical

Division or Vital Records, P.O. Box 68760,

	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 2 ☐ Feta 4☐ Pregnant at time of a 9☐ Unknown			
ar	t 11. Other significant conditions of Hepatitis C	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2
	Prostate Can	cer			24a. Was an autopsy performed? 1 Yes 2 No
	Was case referred to medical examiner?	Hospital:			ath (Check only one)
	1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ [DOA 4 Nursing H	lome 5 🗆 Residence
	Manner of Death 1 ☑ Natural 5 ☐ Pending investigation 2 ☐ Accident		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur
	2 □ Suicido 6 □ Could not be	A		4	

25 2 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

pa Koshyn M.P

Koshu

29c. License number 29d. Date signed (Month, Day, Year) NPI: 1003010943 01-14-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, MD 21201 10.N. Greene

State Registrar

after

2 00

To the Hospital

1M.D Ancopa 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 14, 2008 10:15 AM™ January Nancy Lee Aldrich /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 ☐ M 2 ☑ F 68 1939 Director 214-36-8808 Mar 15, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐ Yes 2√☐ No MD Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4357A Cooper Road 21160 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. white Specify: <u>გ</u> 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mangine. Elementary/Secondary (0-12) College (1-4or 5+) 0 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Howard Klein Mabel Ruth Hooper ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis E. Aldrich III/son 4357 Cooper Road Whiteford, MD 21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical attending physi IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown filled in by the funeral director, page 2 should HITPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Aldrich Nancy MSCO30017 Division or Vital Records, P.O. Box 6876

State Registrar

Medical

29a. Certifier (Check only one)

VIJAT

31. Date filed (Month, Day, Year) JAN 1 8 2008

29b. Signature and title of certifie



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTH AVE. BEL AR MD 21014 32. Registrar's Signature Cooke)

within 2 To the

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D25027 JANUARY 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES HOWARD BLAUVELT Month Day /Medical 2:05 A JAN. 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL LUTHERAN VILLAGE WESTMINSTER CARROLL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 218-24-9651 Director 89 9/26/1918 MARYLAND Usual Residence of Decedent 10a. State 10b. County or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director MD CARROLL 1 Yes 2 □ No WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 ST. MARK WAY, APT. 225 Funeral filed within 72 hours after death Hygiene. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 δ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WWII Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 TROUBLE MAN UTILITY CO. and Mental Hygin traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be WALTER MARTIN BLAUVELT ပ EUTHA ELEANOR KEYSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health as Important: if item 27 is eny injury or other trau RITA M. PATTERSON-DAUGHTER 602 LYNN AVE., AMES, IOWA 50014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EVERGREEN MEM.GARDENS 1/21/08 FINKSBURG, MD atury 1 Peral Prvice Licensee 21. Si 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, 21157 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Parti. En Approximate Interval Between Onset and Death Immediate Cau (Final **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical as the IF FEMALE: esn 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery page 2 should be detached for in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) the Day Year 9 Unknown ģ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 3 Probably 4 □Unknown this cartificate has 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was aп autopsy performe 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2**X** No Certification: To 1 Tes Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. Director: investigation filled in by the 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours effer To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check out 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Topleted cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

			1 - For State Registrar	State of Maryland /	Department of Health an Certificate of Death	nd Men	tal Hygier	ZUU0	00902
	Physici		1. Decedent's Name (First, Middle, La	st)	Batas	l N	Date of Death	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (II not institution, giv 3118 Tucker	D	4b. City, Town, or Location of D			4c. County of De	9
	Funeral Director		5. Social Security Number 6. S	Fex 2 F- 7. Age (In yrs. last I		Min.	Pate of Birth Wonth, Day, Yea D. 28, 1	9. B	rthplace (State or Foreign Country)
	ehow	25	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the A t or 28e-f	by Funeral Director	10e. Street and Number	e R	10f. Zip Code		10g. (Citizen of What C	
	er death teme 23	uneral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify)	Yes or No- n, etc.)	14. Race - Am Black, Wh	
0036	hours aft lural', or i	d by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 € No Specify:		1.00	Specify: U	Ohite.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It item 27 is marked other then "netural", or items 23a or 28e-1 ehow progrant: It item 27 is marked other then "netural", or items 23a or 28e-1 ehow program in your other treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) ONLIMATELY	f working	166.	Kind of Busines	s/industry
Maryland 3	should be filed nd Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last,	mleu		Name (Firs	Ha +		
	and 2 sho Balth and I n 27 is ma		14 Informant's Name/Relationshi	Jone 3	9b. Mailing Address (Street and Number of	S 1	eet 1	y or Town, State,	Zip Code)
Baltimore,	Pages 1 nent of Hi ant; it iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inditional field State	of Disposition (Name of ery, crematory or other place)	Date / 18.		Location - City o	r Town, State
Balt	permit. Departr Imports eny injs		21. Signature of Funeral Service Licer		22. Name and Address of Facility	Seive,	Forest	HIST, MD	21050. ter-Bolfic
	Physician		23a. Part 1. Enter the disease, or comshock, or heert failure. List only Immediate Cause (Finat disease or condition		not enter the mode of dying, such as call	rdiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence		<i>U.</i>	466		
7.	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	e of):				
ກ,0978	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequence	9 of):				
Вох 68	leath certifica attending ph I for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_			23d. Date of de	alivery
.O.	t the death by the atte ached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)			Month	Day Year
rds, P.	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	_ 4	. /		to the cause of death? Probably 4 Dunknown
Vital Records,	sicion: The law requ certificate has been irector, page 2 shoul	Completed				-	24a. Was an autopsy performed?	24b. Were a prior to death?	
		Be	25. Was case referred to medical examiner?	Hospital:		Death (Che	eck only one)		s 2 No
0	g Phys er this eral dir	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Outpatient 3 DOA Other: 4 Nursin	ng Home 28d. (5 Residence escribe how in	6 □Other (Spi	ecity)
Division of	N or Attending Physicien: after death. I Director: After this certifica d in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	28f I	ocation (Street	and Number or F	Rural Route Number,
ă	pital or yours after erai Dire	Certi	4 ☐ Homicide determined 29a. Certifier 0★ Certifying Ph	building, etc. (Specify)		-	City or Town, Sta	ite)	
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by th	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	ysician: 10 the best of my knowled in inner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and p ind/or investigation, in my opinion, death of 29c. License number	occurred at	the time, date a	nd place, and du	e to the cause(s)
	E 2 5 8	-	I fram 1	SA m	032543		290. [Date signed (Mon	
	10		30. Name and address of person who	completed cause of death (Item 23a	(Type, Print) 6 701 N. C	ha le	5 5+		
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Costs				
			W 1 4 5 4		***				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00903 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 12:41 AM Physician Jamuary 12, 2008 Year Edward H.E. Buckheit /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Harford Examiner 4b. City, Town, or Location of Death Bel Air Upper Chesapeake Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) 69 vrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 215-34-8879 XXM 2 F 17,1938 Mary Land January Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Whiteford MD 1 ☐ Yes 2XNo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21160 2823 Whiteford Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2XXNo Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Analyst 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration 12 h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Roxy Irene Bennett Be Peter Edward Buckheit injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number City or Town, State, Zip Code) 2823 Whiteford Road-Whiteford, Maryland 27160 permit. Pages 1 and 2 a Department of Health an Important: If Item 27 Is any injury or other trau once. Constance Buckheit-spouse 20b. Place of Disposition (Name of EVANS FUNERAL CHAPEL AND OREMATION-BEL AIR 20a. Method of Disposition 20c. Location - City or Town, State
Forest Hill, Maryland 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Jan 17 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3 Newport Drive EVANS FUNERAL CHAPEL, 3 Newport Drive AND CREMATION SERVICES Forest Hill, Maryland 21050 h ME Frods ondrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evere **Physician** a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Sequentially list condition that y leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Lorge a exhaumence off Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Tachycardia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the Host within 24 ho To the Fune (Check only 29c. License number 29b. Signature and title of certific

State Registrar 30. Name and address of person who

lanuel

31. Date filed (Month, Day, Year)

azation

DHMH 17 Rev 1/2001

Baltirhore,

Records, P.O. Box 68

Vital

Aberdeen, Maryland

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

m.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yea 2:00 A M 2008 Boyd /Medical James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday If Unde Hours Birthplace (State or Foreign Country) **Funeral** Year) Months Min Days 1**∑** M 2 □ F Director 3-28-1948 214-50-0845 59 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Director Baltimore 1 XYes 2 No N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S 4005 The Alameda 21218 U Α Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2√ Married ☐Yes 2 Yes, Give 2XNo Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) City of Baltimore College (1-4or 5+) Elementary/Secondary (0-12) 12th grade <u>Commercial Driver</u> l vear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Samuel Lee Boyd Elizabeth Drummond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21218 4005 The Alameda Balto, Arnetta Boyd - Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 1-19-2008 Randallstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E. North Avenue Balto, 21202 MD 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1192 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician ar s the burial-t Division or Vital Records, P.O. Box 68760, by Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 DNo Hospital: 2 1 Inpatient 2 □ R/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) and address of person 9 San

Registrar
DHMH 17 Rev 1/2001

State

Date filed (Month, Day, Year)

8

2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16a b per fth 8875 1-18-08 vt
State of Maryland Department of Health and Mental Hygiene 1 - State Registrar

1- State Registrar Amend #20b Per FH G875 1/22/08 tille ate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Day MARGARET E BREW 13/ 4:16 PM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 M F 219-01-7859 MARCH 16,1929 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Mediral Examiner must be notifled at 10d. Inside City Limits 1⊠Yes 2□No Funeral Director MARYLAND 10e. Street and Number 10g. **Ø**itizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? NORTH 45A 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☒ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **Packer** Il Hygiene. Druid Hill Park Seed Co Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (MN - UN KAROUN) Be RESTO MOLLIE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON ANNAPOLIS THOMAS GILBERT BALTIMORE, 140 21230 20c. Location - Citý or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD Facility 21. Signature of Funeral Service Licensee TR. FUNERAL HOME luamo F-4LTON BALTO, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SELSIS FROM BACKETIAL INFECTION IN BLOOD unianoun, /Medical Due to (or as a consequence of): estimated Examiner 24 hours CONVESTIVE HEART FAILURE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PENAL INSUPPLUENCY CHRONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed? 2 C No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending investigation Injury n 24 hours after death. he Funeral Director: Apletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

PASMA AM, MD

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32. Registrar's Signature

100 1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASHA AU

31. Date filed (Month, Day, Year)

AU417336435A18123

Baltimore MD 21201

14/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Claude Bureau January 1:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 622 Ayrlie Water Rd. Gibson Island Anne Arundel 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 194-32-8702 Director 76 March 1931 France Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Md. **AACo** Gibson Island 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 Ayrlie Water Rd. 21056 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inforciart: If item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examines ones. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Bureau Madeline ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Bureau 622 Ayrlie Water Rd. Gibson Island, Md. 21056 (Spouse) 20a. Method of Disposition
1 ☐ Burial 2 AD Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 1/17/08 Baltimore, Md. f Funeral Service 21. Signature 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nelanoma **Physician** iren /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1 Yes 2 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

PA 31. Date filed (Month, Day, Year)

JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

18

32. Registrar's Signature

29c. License number

29d, Date signed (Month, Dav. Year)

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		State of Mar				d Mental Hy	giene		
		State Registrar	Ce	rtificate of	Death		Reg. No.	008	00907
Physic	ian	1. Decedent's Name (First, Middle, Last) Beverly Jean	Kite	Bartkowi	a k	2. Date of De Month	Day	Year	3. Time of Death
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- LAGIII		Franklin Square Hospital	center	Δ	oseda	10	6)	more
Funera		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days			h y, Year)	9. Birthp	lace (State or Foreign
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Mal Mal Mal Man Man Man Man Man Man Man Man Man Man		19a. Informant's Name/Relationship (Type. Print) Linda Coccagna (Daughter) 196. Mailir	ng Address (Street Prince E:	and Number or ric Lane	Rural Route Number	er, City or To Dast ,	wn, State, Zip Florid	<i>Code)</i> а 32164
other		20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other pla	cel	Date	20c. Location	on - City or To	
altimore, altimore, mit. Pages 1 ar partment of Hea portant; if Item; y injury or othe		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Hilltop			/21/2008	Towso	n, Mar	yland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee	22	Name and Addre Duda-Ruc 7922 Wise	ss of Facility k Funera	al Home of	f Dund	lalk, I	nc. 222
		23 art1. Enter the disease, complications that caused the shock, or heart failure. only one cause on each line.	-						Approximate Interval Between
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cate be executed physician and the burial-transit	E	resulting in death) Last Due to (or as a co	onsequence of):						
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vision or Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific releath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome pf		3			23d.	Date of delive	ry
P.O. Box that the death cer ed by the attendin detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 2 ☐ Vertice with 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown]Ectopic pregnancy] Other (specify) _	<i>'</i>			Month	Day Year
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Vital Records, F sician: The law requires the certificate has been signed rector, page 2 should be del	d by	are in other significant conditions contributing to death but in	or resulting in the di	idenying cause giv	enin Faiti.	23e. Did to	\/		e cause of death? ably 4 ∏Unknown
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Or / Physk This c	ို	1 ☐ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient		4 LI Nursing	Home 5□ Resid)
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Hospital or Hospital or 24 hours afte Funeral Dir tely filled in I	Certification:					City or Tow			
Divisic To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of moderate in the desis of examiner: On the basis of examiner and manner stated	amination and/or inv	occurred at the tire vestigation, in my co	me, date and pla ppinion, death oc	ce, and due to the c curred at the time, o	cause(s) and date and plac	manner as sto ce, and due to	ated. the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date sig	ned (Month, L	Day, Year)
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10		on Name and address of person who completed cause of death of the property of	1 (Item 23a) (Type, F	Print)	n () estima	ino ha	141.	to we	מיבונות
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	11 1900	WE DI	IVE, DA	TIMO	15 11	V, 3195/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:55 A ^M Daniel Matthew Boyce, Sr. J<u>anuary</u> 11, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice <u>Baltimore</u> Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Sex X□M 2□F **Funeral** Months Days Hours Yrs 217-80-0640 46 1961 Maryland Director Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MDBaltimore Arbutus Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5704 First Avenue 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail General Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry David Boyce Mary Margaret Storrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paula K. Boyce - Wife 5704 First Avenue, Arbutus, MD 21227 20b. Place of Disposition (Name of Westmetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 1-15-2008 Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Montas **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 1 ☐ Yes 2 ☐ No Pathologic Fractine 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sether (Specify) WOSPCO 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 11 2008

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BURC AURA 9:10 AM TANIUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number)
HARROR HOSPITAL
3001 SOUTH HAMOUER 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE STREET Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Yea 9/3/1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 Z F 217-80-0587 47 Director Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No md. Baltimore 2825 Alabama Ave. Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Alabama Ave. 21227 death v Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretery Investment permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Benjamin Sims Ula Mae Burrell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Burg - son 214 Hillendale Ave. Lansdowne, MD. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge 1/18/08 4 □ Donation 5 □ Other (Specify) Elkridge, MD. 22. Name and Address of Facility 2719 Hammonds Ferry RD., Ambrose Funeral Home of Lansdowne MD. 21727 21. lignature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BASALGANGLIA & OCCIPITAL STROKE. **Physician** /Medical Due to (or as a consequence of): 5 DA45 **Examiner** ASPIRATION PNEUMONIA Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ UNICONTROLLED DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy certificate performed 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. the Funeral Director: After 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONITE THEACLUARA, 3001 SOUTH HAMOVER STREET, RALTIMORE, MARYLAND 21225

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Lucqua, G

RES 000

JANUARI 14 2008

J. State

Registrar

RES-000

Johns Hopking Hospital, 600 North Wolfe Street, Baltimore, MD 21287

January 13, 2008

Physician

32. Registrar's Signature

1.48 A

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

200

William Kostis, PhD, MD

JAN 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1191 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** JANUARY 14,2008 COLGAN ELAINE KATHERNE 11:144 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNSHOPKWS HOSPITAL BALTIMOLE CTY Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F Director 217-76-4765 02/05/1961 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show 28a-f sh notified 1 □Yes 2√No Director MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 2419 Pocock Road U.S.A. 14. Race - American Indian, 21047 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status r than "natural", or iten the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X** No 1 ☐ Yes 2 No Specify. **≥** Specify: 3 ☐ Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Senior Claims Representative | Insurance Industry if Health and Mental Hygie item 27 Is marked other i other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Carl Brown Sophie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tronce. 2419 Pocock Road - Fallston, Maryland 21047
of Disposition (Name of Date 20c. Location - City or Town, State Clarence J. Arbogast (fiance') 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gds.01/19/2008 Fallston, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assal 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STROKE 8 DAYS /Medical Due to (or as a consequence of): HYPERTENSION 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐,Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 Unknown page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Examiner Division or Vital Records, P.O. Box 68760. within 24 hours after death. To the Funeral Director: After To the Hospital or completely filled

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

MAJIDA 31. Date filed (Month, Day, Year) State JAN 18 Registrar

29b. Signature and title of certifier

MAJIDA



and manner stated.

MANISTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1300

29c. License number

600

RES-000

N. WOLFE ST.

29d. Date signed (Month, Day, Year)

BALTIMORE MD 21287

JANUARY 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15, CHRISTOPHER MAURICE BONNER CARNEY JANUARY 2008 5:35 A /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center Forest Hill
Under 1 Year | If Under 24 Hrs. Harford Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 76 Months 1**√** M 2□ F Director 182-24-2625 Aug. 21, 1931 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 533 E. Jarrettsville Road 21050 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Catholic Priest Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice J. Carney Dolores (UNK) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Msgr. James M. Barker / Friend 533 E. Jarrettsville Road, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 □Removal from State 4 □ Donation 5 □ Diner (Specify) Hilltop Service Corp 1-18-08 Hilltop Service Corp. e of Funera 21. Signati r ice Lidensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lowe if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine attending physician and for use as the bear and The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Division or Vital the Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Iniury 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) To a Gause of death (Item 23a) (Type, Print)

500 upper Chesapeake Dr. Bel Air, MD

32. Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammed Tokhadav 31. Date filed (Month, Day, Year) State Registrar

M80041769A

			For State Registrar		State of	f Mary			rtment of tificate of			-	giene Reg. No.	2008	00913
	* Physici	an	Decedent's Name (First, Michael Control of the	idle, Las								2. Date of Dea	ath		3. Time of Death
	/Medi	cal	Rosemarie 4a. Facility Name (If not institut	ion aive	E street and pur			CI	emens 4b. City, Town,	or Legation		Januar		2008 Year	14:56 M
-	Examir Funeral Director	ier	Anne Arundel N 5. Social Security Number 113-54-0518	edic	al Cen	ter	yrs. last birt	'hday) Yrs.	Annapo If Under 1 Year Months Days	lis If Under	24 Hrs.	8. Date of Birt (Month, Da	An h v, Year)	ne Arun	de1 nplace (State or Foreign untry)
	D.		Usual Residence of Decedent									Dec.28	,195	9	NY
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	r 28a-i	rect	MD Anne 10e. Street and Number	Arui	idel		Crown	SV1.	10f. Zip Code				10g. Citi	izen of What Co	
	ath with unit 23a o	ra D	410 Serpentine	Tra	il				210	32			U.	S.A.	
036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorc		12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 X No /e	in U.S.		/as Decedent of Yes, specify Cul ☐ Yes 2\\\ No			cify Yes or No- lican, etc.)		14. Race - Amer Black, White Specify: Wh	e, etc.
1215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural"; or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	hest grad	ication le completed) College (1	-4or 5+)		(Give k life, D	ent's Usual Occu ind of work done O NOT use retire	during mos ed)	st of working	g	16b. Ki	nd of Business/I	ndustry
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e, Maryland	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic enone.		19a. Informant's Name/Relatio Mr. Randy Cler				41	0 S	erpentin	e Tra	il Cr	ownsvi.	11e,	r Town, State, Z MD 2103	32
baltimore,	t. Pages triment of Frant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)		State E	cemeter	vil:	ition <i>(Name of</i> atory or other pla Le Crema	tory!(Da 1-18-	-2008	Br	cation - City or 1	le, FL
g R	Depa Depa Impo any ii		21. Signature of Funeral Servi	Licens		0	479	1	2nd Ave	ess of Facili	Glen]	Burnie,	MD	ral & Cı 21061	cemation Srv
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	or comp	aC	ach line.	death. Do n	4	the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
6/00,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	l	Due to (d	or as a co	nsequence o	f):							
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	2	23c. If yes, outo 1 □ Live bi 4 □ Pregna 9 □ Unkno	irth 2□ ant at time	Fetal death	3 🗆 l	Ectopic pregnand Other <i>(specify)</i> _	гу			2	23d. Date of deliv	very Day Year
cords, r	equires thaten signed build be det	þ	Part II. Other significant cond	tions co	ntributing to de	ath but no	t resulting in	the und	derlying cause gi	ven in Part I		III		se contribute to ☐ No 3 ☐ Pro	the cause of death?
ם שני	t: The law ricate has be	Completed										24a. Was a autop perfor 1 Yes	sy	24b. Were aut prior to co death? 1 ☐ Yes	copsy findings available completion of cause of
<u> </u>	s certifi	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	-	Hospital:	npatient	2 ER/Out	nationt	3 DOA Oti			Check only or			
5	ng Phy fter thi	\vdash ι	27. Manner of Death	ina	28a. Date o	·	28b. Ti		28c. Inju			e 5 Ll Hesid 3d. Describe h		Other (Spec y occurred	ify)
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	2 Accident inves	tigation	28e. Place buildir	of injury - , ng, etc. <i>(S</i>	At home, farr			Yes 2		if. Location (S City or Tow	treet and n, State,	d Number or Rui)	ral Route Number,
	e Hospita 24 hours e Funeral etely filled	Medical C	29a. Certifier Check only one) Certify 2 Medica	ing Phy al Exami	sician: To the ner: On the ba and mann	isis of exai	knowledge, mination and	death l/or inve	occurred at the ti estigation, in my	ime, date ar opinion, dea	nd place, ar ath occurred	nd due to the o	ause(s)	and manner as place, and due	stated. to the cause(s)
	To th within To th сопр	Me	29b. Signature and title of certif		7				29c. Licens		21	2	9d. Date	e signed (Month	, Day, Year)
	10		30. Name and address of person			of death	(Item 23a) (T	ype, P	rint) hie	4:1	86	0 ~	10	111010	51017
	Stat Registra		31. Date filed (Month, Day, Yea	2008	60	gistrar's S		234	Bando .	س ان ام د	<u> </u>	W.W.	THE STATE OF THE S	7-013	0,0,2
	regioni				4		0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Month Day Maria Clevenger 7, 2008 AMJanuary 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 57 Director 272-56-0624 Germany October 25, 1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d, Inside City Limits at must be notified 1 ☐ Yes 2 X No Directo Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18665 Nathans Place 20886 United States Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County, MD Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Aide Public Schools Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ziva Popov ဥ Erna Albrecht 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angie M. Clevenger / Daughter 18665 Nathans Place, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 11 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 All Souls Cemetery Germantown, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc., 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue, -2805 21. Signature of Funeral Service Licensee Rockville, Rockville, M01473 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive Heart **Physician** Failure houns /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐Ectopic pregnancy Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy pertormed' 1 ☐ Yes 2 PNo 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruckuille, mo20850 J. Shemilimp 9901 medical

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Yes

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32. Reg

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Robert Henry Cremen, Sr. 8:29AM 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner The Good Samaritan Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Days Hours 219-38-0335 Director 01/26/1942 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c must b 2 Copewood Court United States 21102 Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Consultant Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert A. Cremen Gertrude Corcoran P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any injury or other trau Patsy R. Cremen / Wife 2 Copewood Court Manchester, MD 21102 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory 01/15/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hubbard Funeral Home, 'Maut 4107 Wilkens Avenue Baltimore, MD 21229 23a. Part1. Enter the dise se shock, or heart failur. mply ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): Minuks /Medical Examiner Massive Recentt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death2 1 Yes 2 No 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year) 229419 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Baltimore, Blvd. Sandeep Singh, MD 21239 M 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 1 8 2008 JAN Registrar

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	Examin	er	4a. Facility Name (If not institution, give				4	b. City, Town, or		of Death		4	lc. County		
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	Funeral Director			M 2□F	76			Months Days	Hours	Min.	pr 24	y, Yea	931	Ver	lace (State or Foreign htry) nont
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	r dea tems er mi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	405	3. 13.	Wa:	s Decedent of Hi es, specify Cuba	ispanic Orig	gin? (Specif	y Yes or No can, etc.))		e - Americ	
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ה ה	72 hc 'natu dical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	11	16a. Dece	den kin	it's Usual Occupa od of work done o NOT use retired	ation during most	t of working	T T	16b.	Kind of Bu	usiness/Ind	dustry
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<u>a</u>	should be nd Mental marked o	To Be	Armand Dumas						Ar	mande	St. 1	Den:	is	,	
3	shou ind M mar	-	19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	ng A	Address (Street &	and Numbe	er or Rural F	Route Numb	er, City	or Town,	State, Zip	Code)
Š	and 2 alth a 27 is er tra		Mary J. Dumas, W	ife		9313	Th	nornewoo	d Dri	.ve Pa	rkvil	le,	Mary	land	21234
ē.	es 1 a of He		20a. Method of Disposition	tamous from Ctata	20b. Pl	ace of Dispo	ositio mat	on (Name of lory or other place	e)	Date	e	20c.	Location -	City or To	wn, State
Dallimor	t. Pagr tment tant: It		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Met			natory I						•	Maryland
0	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evoluce.		21. Signature of Funeral Service Leaps Thomas Gregor	چ ا		2		lame and Addres emation Freder	Socie	ty Of Road B	Mary. Saltim	lano ore	d, Ir Mar	nc. Vlan	d 21228
M			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each lin	the death										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DIA	res	* m		phop							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):		0	1						
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לם .	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3		ctopic pregnancy ther (specify)	,					te of delive onth	ery Day Year
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Į.	an: T	Be C	25. Was case referred to medical						26. Place	of Death (1□ Yes Check only o		No	1 □ Yes	2 No
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2	endly sath. or: A	atic	2 ☐ Accident investigation					M 1 🗆 Y	Yes 2 □ I	No					
	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At hou . <i>(Specify</i>	me, farm, str	reet	, factory, office		28f	Location (S City or Tox			er or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examinat	vledge, deat ion and/or in	h oo	ccurred at the tim stigation, in my o	ne, date an pinion, dea	id place, and ath occurred	d due to the at the time,	cause date a	(s) and ma and place,	anner as s and due to	tated. the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	0				29c. License	83	03		29d. [ate signe	d (Month,	Day, Year)
	10+1		30. Name and address of person who co	Impleted cause of de	eath (Item	23a) (Type,	Prir	N. CE	rance	& St	- De	~SU	NM	D Z	2008
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signat	ure	1								
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				623											

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Albert Dumas 1/15/05 0110

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Stanature

30-Name and address of person who completed cause of death (Item 23a) (Type, Print) Meade Rd Winthicom MD I 1090

29c. License number

29d. Date signed (Month, Day, Year)

ANAT 18-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Ellis Dudney January 07:00 AM James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 326 Green Drive Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCt. 30 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 239-56-2775 78 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 ☐ Yes 21 No Director Maryland Anne Arundel Pasadena 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Green Drive 21122 USA items 23a death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White etc. filed within 72 hours after of Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Superintendent Commercial Building permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Lerue Dudney Tinv Strickland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Dudney (son) 326 Green Drive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc Baltimore, Maryland 2008 21. Signature of Funer in Service Li 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. 23a. Part 1. Enter the disease, or complicition shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ∀rcinoma of Lung 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No certificate has page 2: autopsy 2 X No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division or Vital Records,

SXI

State

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause

Registrar

DHMH 17 Rev 1/2001

of death (Item 23a) (Ty

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2 1 18

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		-65	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Margaret Frances I	Drisgill				January			7:20 ^{a м}
	Examin		4a. Facility Name (If not institution, give s	· ·		4b. City, Town	, or Location of Dea	th	4c.	County of Death	
, , , , , , , , , , , , , , , , , , ,	Significant de la company de l		1511 Adamsview Roa		4 5 5 45 45	Cato	nsville ar If Under 24 Hrs	10 Date -(Bit		Baltim	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	Yrs.	Months Day		. (Month, Day	n y, Year)	Cour	*2
г	Director		219-10-0644 Usual Residence of Decedent	82				01/10/	1926	Mar	yland
	/land ow at		10a. State 10b. County	10c. City	, Town or Loc	cation				1	0d. Inside City Limits
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	th the	Director	10e. Street and Number			10f. Zip Code	9		10g. Citi	zen of What Cour	ntry?
	th will	je,	1511 Adamsview Roa	ad			21228			United :	States
	r dea tems er mi	Funeral	11. Wantai Status	Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Yes, specify C	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	.	 Race - Americ Black, White, 	
စ္	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by Fi	1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ M No If Yes, Give	1	□Yes 2 □N	o Specify:			Specify: Wh:	ite
215-0036	hour tural' al Ex		15. Decedent's Educ	Year or Dates:	16a Deced	ent's Usual Occ	cupation		16h Ki	nd of Business/In	dustry
င်	in 72 "na" r	Completed	(Specify only highest grade	completed)	(Give i	kind of work dor OO NOT use reti	ne during most of wo	orking		, id of Buomoco, in	22 5y
7.7	with jiene. r thar the N	m o	Elementary/Secondary (0-12)	College (1-4or 5+)		al Secre			Lá	aw Office	e
0	e filec al Hyg othe /ent,	BeC	17. Father's Name (First, Middle, Last)	·			18. Mother's Na	me (First, Middle,	Maiden	Surname)	
yland	uld be Jenta rked tic ev	To E	Fred Snyder				Emma	Frances	Sny	der	
Mar	sho and l	ľ	19a. Informant's Name/Relationship (Typ	e. Print)			et and Number or F				,
Ξ. Ξ	and and in 27		Mr. Robert Drisgi				iew Road,				
ore	ges 1 F of H		20a. Method of Disposition 1			sition (Name of natory or other p		Date		cation - City or To	
E	. Pag tment tant: jury		4 ☐ Donation 5 ☐ Other (Specify)				etery 01/2	22/2008	Balt	timore, 1	Maryland
gaitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License Malut-Zoo	e		. Name and Add	•	Hubbard.	Fune	eral Home	e, Inc.
	₽₽ = # O		23a. Part1. Enter the disea	untings that sound the death			kens Avent			e, Maryla	
			shock, or heart failure. List only on	e cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of the second of	u n	napho	Spert				
	Examiner			Due to (or as a consequ	ence of):	i Kes	nd Will	Corun	ma	,	
L		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ							
	d d ansit	Examiner	that initiated events								
o,	an an rial-tr		resulting in death) Last	Due to (or as a consequ	ence of):						
68/60,	e law requires that the death certificate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	Medical	d.								
õ ×	ertifica ing ph e as t	Med	IF FEMALE:								
Q Q	death ce e attend ed for use		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnal 1□Live birth 2□Fetal	death 3	Ectopic pregna			1	23d. Date of delive Month	ery Day Year
_	the a	Physician	1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eatn 5∟	Other (specify)					
J.	requires that the een signed by the hould be detache		Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	derlying cause	given in Part I.	23e. Did to	obacco u	use contribute to t	he cause of death?
ds	uires sign d be	d by						1 🗆 🗎	Yes 2	ZHO 3□ Prol	oably 4 □Unknown
ecord	law req as beer 2 shou	lete					· -	24a. Was	an	24b. Were auto	ppsy findings available
e L	The la	Completed						autor perfo	osy rmed?	prior to co death?	mpletion of cause of
VItal			25. Was case referred to medical				26. Place of De	1 Yes eath (Check only o		1 □Yes	2 □ No
	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 Z No	ospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatien	t 3 DOA)ther:	Home 5 Aresid		6 □Other (Specia	fy)
יסר	ding Phys h. After this funeral dir	n: T	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Ir	njury at Vork?	28d. Describe I	how inju	y occurred	,
sion	endir ath. or: Af he ful	atio	2 ☐ Accident Investigation				☐ Yes 2 ☐ No				
	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, offic	ce	28f. Location (S City or Tox	Street an vn, State	nd Number or Run	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		00-0-45-	i-tT	alada 1						
	Hosp 24 hol Fune rtely f	Medical		ician: To the best of my knowner: On the basis of examinat and manner stated.							
	o the ithin : o the omple	Mec	29b. Signature and title of certifier	and manner stated.			ense number			te signed (Month,	Day, Year)
	⊬≯⊩ŏ		· Chille	Kurch		D	349,7				m 17 2003
	F		30. Name and address of person who con	npleted cause of death (Item	23a) (Type-1	Print) /	349,7 Udr. kil		4		J.
11	U		EDMUND CO	Kornik 4		desh.	Hour XIC	10 Comon	116	is Zilly	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registràr's Signat	ture	A10					

			For am	nend #15	5,2State of 2	Marylan Per	d/Ben	artment				ental Hy		2000		020
	-	-	Registrar 1. Decedent's Name					imeate	01 2	Jean		2. Date of De		2000	3. Time of	J C U
496	Physici			n Ducket	,							Month Januar	Day	2008	9:50	
1	/Medi				give street and number	er)		4b. City, T	Fown, or	Location o	of Death	Januar	Ť	County of Dea		LFI
	Examir	ıer			's Medical		r		ver		or Bourn				eorge's	
45.0	Funeral	2.0	5. Social Security Nu		i. Sex 7.		last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9. Bir	rthplace (State	or Foreign
	Director		579-20-84 Usual Residence of I		1 M 2 □ F	82	Yrs.	Months	Days	Hours	Min.	(Month, Da Apr 20			ountry) shington	n DC
	/land ow at			10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Mar Ff sh fied	ţċ	MD	Prince	George's	Cap	ital H	eight	s						1 □Yes	² X No
	with the	Funeral Director	10e. Street and Num 1117 Cha		d Lane			10f. Zip (Code 2074	3			10g. Citiz	en of What C	ountry?	
	death ms 2	nera	11. Marital Status		12. Was Decede	nt Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Am		
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Marrie		Armed Force d 1/2 Yes 2 [If Yes, Give Year or Date:	No		if Yes, speci 1 □ Yes 2		n, Mexicar Specify:	n, Puerto	Rican, etc.)		Black, Whi		
2-0	72 hornatur	Completed by	(Special	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual kind of work	l Occupa	ation	t of workii	na	16b. Kir	nd of Business	s/Industry	
21	ithin ne.	ng u	Elementary/Secon		College (1-4c	or 5+)	life.	DO NOT use	e retired,)	e or workin	'g				
21	filed w Hygier ther the		unk 10 Y		unk		senio	r cit	izen						tation	
Ĕ	d d d d d d d d d	Be	17. Father's Name (F	First, Middle, La	ast)			uı	nk			(First, Middle,	Maiden	Surname)		
Ž	2 should be and Mental Is marked o aumatic eve	၉	40a Informantia Nav	ma/Dalatianahir	(Time Brint)		106 \$4500	A	/C4== =4 =			Clark	04		Ti- O-d-l	
Ma	is all		19a. Informant's Nar Valerie		t/spouse			-				<i>Route Numb</i> Canita			MD 2074	.3
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		20a. Method of Dispo			20b. F	Place of Dispo	_				ate		cation - City or		
Baltimore,			1 ☐ Burial 2X 4 ☐ Donation	Cremation 3 5 NOther (Spe	B□Removal from Sta Holfy) in Stat	le _	e Crem	atorv		1 1	2/01,	/2008	Cli	nton. I	Md.	
Ball	permit. Page Department of Important: If any injury or once.		21. Sign iture of Euro	neral Service Li	censee Williams	rector	2120	vart. hu 1 4001	nera Benn	.Hom ing Rd	. Wash.	p.c.				
			23a. Part1. Enter the shock, or heart	e disease, or co t failure. List or	omplications that caus	sed the deat line.	h. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Ap 200 Interval Be	tween
A	Physician		Immediate ause (F disease or o dition	Final I	_a septi	c sho	ck								Onset and 3 day	'S
	/Medical Examiner		resulting in death)	- (Due to (or a	as a conseq	uence of):									
B		ë	Sequentially list condif any, leading to imr	ditions, mediate	b. urose Due to (or a	psis as a conseq	uence of):		_					-	4 week	is
	uted d ansit	Examiner	Sequentially list confidence in any, leading to impossible. Enter Cause (Disease or in that initiated events	njury	e renal	fail	ure								l year	•
o,	te be executed ysician and e burial-transit	Exa	resulting in death) La	ast		as a conseq										
	± × 5 €	lical			d											
x 68	death certificat attending phy I for use as the	Mec	IF FEMALE:	1	00.46											
Вох	ath c attenc for us	ian/	23b. Was decedent in the past 12 n		23c. If yes, outcor 1☐Live birth	2 🗆 Feta	ıl death 3 ☐	Ectopic pre					2	3d. Date of de Month		Year
o	at the de by the a tached f	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□Unknown		leath 5	Other (spe	ecity)						,	
P.0	that t ed by detac		Part II. Other signific	cant condition	s contributing to death	but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	se contribute t	to the cause of	death?
ords,	w requires been sign should be	ted by			diomyopath							1 🗆	Yes 25	(No 3□F	Probably 4 🗌	Unknown
Records,	has has	Completed	conge	stive h	eart failu	ıre							osy ormed?	prior to death?	completion of c	available cause of
		Be C	25. Was case referre	ed to medical						26. Place	of Death	(Check only of	2 No	1 □ Ye	s 2□No	
>	Physiclan: this certific	0	examiner? 1 ☐ Yes 2 █ ਨ	Vo	Hospital: 1 Minpa	atient 2	ER/Outpatier	ıt 3□ DO/	A Othe	.r.		ne 5□Resi		☐Other (Spe	ecify)	
o uo	ding I. After fune	tion: T	27. Manner of Death 1 TatNatural 2 Accident	5 Pending investigat		njury Day Year)	28b. Time of Injury	f 28	Bc. Injury Work		2	28d. Describe				
Division or	i or Attend after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of	injury - At ho etc. (Specif		eet, factory,	office		2	28f. Location (City or To	Street and vn, State)	l Number or F	Rural Route Nur	mber,
-	To the Hospital or within 24 hours after To the Funeral Director Completely filled in binding the complete of	Medical C			Physician: To the be caminer: On the basis	of examina										(s)
	To the	Me	29b. Signature and t	itle of confier	100	YI	411	29c.	License	number			29d. Date	e signed (Mon	th, Day, Year)	
	->-0		Kto	a	71	,	() H)	D	002	8195			Jan	10, 20	008	
			30. Name and addre	ess of person wh	no completed cause o	f death (Iten	1 23a) (Type,							•		
2500			David A	ubrey (Gooray 14	50 Mei	canti	le In.	#21	L7	Larg	o,MD.20)774			
12	Sta Registr		31. Date filed (Month		32. Regi	strar's Signa	ture	المثالة				,				

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep Registrar Ce	artment of Health a ertificate of Death	ınd Mental Hy	ygiene 008	00921
40 5	Physici	an.	1. Decedent's Name (First, Middle, Last)		2. Date of D Month	leath Day Year	3. Time of Death
	/Medic		Rebecca Howard Davis		January	13 200 8	
4	Examin	er	4a. Facility Name (If not institution, give street and number) Single Facility Number S. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Ballomae J If Under 1 Year If Under 24	city	4c. County of Dea	thplace (State or Foreign
	Funeral Director		216-28-6237 1 M 2 K F 77 Yrs.	Months Days Hours	Min (Month, E	Day, Year) Co	ountry)
-	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	conting			10d. Inside City Limits
	faryla shov	or	MD Baltimor				1 Yes 2 No
	the N 28a-1 notifi	Director	10e, Street and Number	10f. Zip Code		10g. Citizen of What Co	
	3a or	J D	3519 Lynchester Road	21215		USA	
	death	Funeral		Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	jin? (Specify Yes or N		erican Indian,
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No Specify:	, r dello nicari, etc.)	Specify: b]	
7	"natu	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	of working	16b. Kind of Business	/Industry
7.	filed within Hygiene. other than "	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	rmacist		retail s	store
7 0	Hyg Hyg other ent, t	Be C	17. Father's Name (First, Middle, Last)		's Name (First, Middl		
<u>ख</u>	uld be Venta Irked Itlc ev	To B	William Henry Howard	Lau	ıra Easter	Wortham	
Maryland	2 should be f n and Mental I is marked of raumatic eve			ing Address (Street and Number			•
	1 and 3 Health im 27 her tr			Lynchester Ro	pad Baltimo		
altimore,	Pages Iment of Hant: If Ite		4 ☑ Donation 5 ☐ Other (Specify)	osition (Name of ematory or other place)		20c. Location - City or	·
ng Ra	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Ronald S. Wade Director S. Ba	2. Name and Address of Facility tate Anatomy Bo altimore, MD 2	, pard 655 W 21201	. Baltimore	Street
	*		23a. Part . Enter the disease or conflications hat caused the death. Do not en ships, a heart failure. List only one cause on each line.	ter the mode of dying, such as ca	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Control Office (Cause Cause			doa	
	/Medical Examiner		Due to (or as a consequence of):	1.1			3 10
8		e.	Sequentially list conditions, b. Due to or as a consequence of):	1S/100	10.00		3020
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	istron Vemenja			500
Ď,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				
08/PN	ate b	edical	d				
	certific ding parse as		IF FEMALE: 23c. If yes, outcome pf pregnancy		7		
O. BOX	death e atter	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
<u>.</u>	requires that the een signed by th nould be detache		Part II. Other significant, conditions contributing to death, but not resulting in the u	underlying cause given in Part I.	23e. Did	tobacco use contribute to	o the cause of death?
Z	quires n sign uld be	d by	1)iggetes Mellips		1	Yes 2 No 3 P	robably 4 Unknown
ecords	law red as bee 2 shou	Completed			24a. Wa		utopsy findings available
	The la	mo:			aut per 1□ Yes	formed? death?	
VII G	ctor, p	Bec	25. Was case referred to medical examiner?	26. Place o	of Death (Check only		2,2110
2	Shysic this co	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient			sidence 6 Other (Spe	ecify)
5	After After f. nera	ion:	27. Manner of Death 1	Work?		how injury occurred	
NISIO O	Attend death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, str			(Street and Number or R	ural Route Number
5	al or /	Certification:	4 ☐ Homicide determined building, etc. (Specify)	, ,,		own, State)	arai ribato rianibor,
	To the Hospita or Attending Physician: The law within 24 hours' fer death. To the Funeral Director: After this certificate has completely filled in by the f. neral director, page 2.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat a constant on and constant on and manner stated.	th occurred at the time, date and ovestigation, in my opinion, death	d place, and due to the h occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	(; /	29d. Date signed (Mon	th, Day, Year)
			MD, MD	Kes-0	00	January 1	3 2007
	- 4		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	11/	January 1	
	Sta	le l	31. Date filed (Month, Day, Year) 32. Registrar's Signature	u 1105/1/4/	of 1) 41pmpre	S
	Registra		JAN 1 8 2008				

			Please T				ndelible li			-		-			
		For		State of I	Marylan		oartment o			Mental Hy	giene				
		State Registrar				C	ertificate d	of De	eath		Reg. No.	2008	_0092	2	
Physicia		Decedent's Name (First	t, Middle, Last)			<u></u>				2. Date of De Month	ath Day		3. Time of Dea		
/Medica	al .	Daism				Lit	emiller			JAN	14	2008	8:22 B	М	
Examine	er	4a. Facility Name (If not in				EDKAL			cation of Death		4c.	County of Dear	th		
	4		OPKINS		IEW C				Under 24 Hrs.	8. Date of Bi	-th-	N/A	W-1 (C4-1		
Funeral		5. Social Security Number 245 – 52 – 2615		M 2 StF	Age (In yrs. 72	Yrs.	Months Da		Hours Min.	(Month, D	ay, Year)	Co	thplace (State or For		
Director		Usual Residence of Dece	dent		12					March	19,1	935 Nor	th Caroli	.na	
at w			County		10c. Cit	ty, Town or	Location						10d. Inside City Lir	nits	
fied fied	ţċ	Maryland	Balti	more						Essex			1 □ Yes 2 🔀	No	
or 28,	Directo	10e. Street and Number					10f. Zip Cod	de			10g. Citi	zen of What Co	ountry?		
23a c		731 Seaw	all Roa	d					21221		Un	ited St	ates		
ems er mi	Funeral	11. Marital Status	1	12. Was Decede Armed Force		.S. 10	B. Was Decedent	of Hispa Cuban, M	anic Origin? (Sp Mexican, Puerto	pecify Yes or No)-	14. Race - Ame Black, Whit			
or it		1 Never Married 2		1 ☐ Yes 2] If Yes, Give	⊠ No		1 □ Yes 21 ∑		Specify:	. ,		Specify:			
ural",	d b	3 ☐ Widowed 4 ☐ D		Year or Date	s:	1			. ,				White		
"nati	Completed	15. D (Specify onl	ecedent's Educ Iy highest grade	cation completed)		16a. Ded (Gi)	cedent's Usual Oo ve kind of work do v. DO NOT use re	ccupatio one durii	n ng most of wor	king	16b. Ki	nd of Business	/Industry		
than Be Me	티	Elementary/Secondary	(0-12)	College (1-4d	or 5+)		itress	eareu)			Da		. 4.		
ther int, th	ပ္တို	11 Years 17. Father's Name (First,	Middle, Last)	IIkn.		Wa	ITLLESS	18	. Mother's Nam	ne (First, Middle	Restaurant (First, Middle, Maiden Surname) Ukn.				
ed o	Be	, , , , , , , , , , , , , , , , , , , ,	,	OKII.		Hens	lev		Corr		,		IVII.		
mark mati	2	19a. Informant's Name/R	elationship (Tvi	oe. Print) Hu:	sband		illing Address (St	reet and			ner. City o	r Town, State	Zin Code)		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mr. Charle:				1	Seawall								
Hea tem other	i	20a. Method of Disposition	n		20b. F	Place of Dis	position (Name of	of	i	Date	20c. Lo	cation - City or	Town, State		
y or o		ValBurial 2 □Crer 4 □Donation 5 □ C		emoval from Sta	ite		rematory or other d Cemete		1/18	3/2008	Ba	1 timore	, Marylan	A	
ortan injur	ŀ	21. Signature of Funeral		ee	(7)			-	1 1				• +	.u	
any one		Tream	2	100	\nearrow	Ļ	22. Name and Ad Duda – Rud	ck F	uneral	Home of	Dun	dalk, I	inc.		
W-1	N	23a. Part1. Enter the disc shock, or he		cations that caus	sed the deat		922 Wise					and ZIZ	Approximate		
		shock, or he Immediate Cause (Final	e. List only on			,							Interval Betweer Onset and Death	h	
hysician /Medical		disease or condition resulting in death)	a		as a conseq	Do L	161						12 hour	2	
xaminer				Due to (of	as a conseq	derice or).									
0 0 0	ē	Sequentially list condition if any, leading to immedia cause. Enter Underlying	is, b		as a conseq	uence of):									
184 E	Examin	Cause (Disease or injury that initiated events	- 1												
sician and burial-transit	Exa	resulting in death) Last	C.	Due to (or	as a conseq	uence of):									
ysicia ie bui	ca		d												
ng ph as th	Jed	IF FEMALE	_								- 1				
endir	₩.	IF FEMALE: 23b. Was decedent pregr	Idill	3c. If yes, outcor 1□Live birth			B⊟Ectopic pregn	ancv			1	23d. Date of de	,		
ed fo		in the past 12 month 1 ☐ Yes 2 ☐ No	is?	4□Pregnan 9□Unknowi	t at time of c		Other (specif					Month	Day Year		
by the	Physician/Medic	9 Unknown													
gned be de	by	Part II. Other significant	conditions con	tributing to deat	n but not res	ulting in the	underlying cause	e given ir	n Part I.				the cause of death		
onld										1	Yes 2[□No 3□P	robably 4. Unkn	own	
as be	Completed									24a. Was			utopsy findings avail completion of cause		
ate h page	Ö									perf 1□ Yes	ormed? 2 No	death?	2 □ No		
ertific ctor,	Be	25. Was case referred to examiner?	_						8. Place of Dea	th (Check only	one)				
his c	2	1 ☐ Yes 2 No	Н	lospital: 1 Inp	atient 2	ER/Outpat				ome 5 ☐ Res	idence	6 □Other (Spe	ecity)		
offer t		27. Manner of Death 1 Natural 5 □	Pending	28a. Date of I (Month,	njury <i>Day Year)</i>	28b. Time Injury		Injury at Work?		28d. Describe	how injur	y occurred			
or: A	cati	2 ☐ Accident	investigation Could not be						2 □ No						
irer d n by	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of building,	injury - At he etc. (Specil	ome, farm, : <i>fy)</i>	street, factory, of	fice		28f. Location City or To			ural Route Number,		
aral C		20 0 111													
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 1 C (Check only one)	ertifying Phys ledical Examir	ner: On the basi	s of examina	owledge, de ation and/or	ath occurred at the investigation, in	ne time, my opini	date and place ion, death occu	, and due to the rred at the time	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)		
thin 2	Med	29b. Signature and title of	f cartifier	and manner	stated.		29c. Lie	cense nu	ımher		29d Dat	e signed (Moni	th Day Year)		
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Stat		31. Date filed (Month, Day	y, Year)	32. Red	strar's Signa	ature	Lange BE B	15	017/10/	(/17)	010	47			
State Registrar JAN 18 2008 32 Registrar's Signature															
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1:55 PM Emmel 2008 Creckac an 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 0117 2611 Old offo Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** M 2 ☐ F Months Days Hours Director 212-07-7179 94 Feb. 19, 1913 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tien 27 is amended other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2611 Old Joppa Road 21085 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Manufacturer Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Henry Emmel Sr. Emily (unk) Waldon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim A. Williams / Granddaughter 7729 Buck Hill Road, Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-08 Franklinville Presbyterian Cem. Bradshaw, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PALICINSONS **Physician** 12158 1958 400-3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown NIDDM Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ASCUD autopsy performed? Yes 2 100 ANEMIA 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 HNatural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 29a. Certifier 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37295 MO 16/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE YZUZ 6701 NCHARLES ST 70 wson MO 21204 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1625 7 M 4a. Facility Name (If not institution, give street and number) 12 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 9 Bithplace (State or Foreign Country) Habran Commenter 125 W If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 □ M 2 🔀 F Days Hours 214-30-1499 88 Director February 9,1919 Czechoślovakia Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 TylYes 2 □ No Director Maryland Montgomery Rockville * 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1189 Potomac Valley Road 20850 United States death Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married o. Specify: White 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) the Own Home Homemaker other 1 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sibrava Anna (not available) ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1189 Potomac Valley Road, Rockville, Maryland 20850 Earl W. Engleman, III /Son 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ½ Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial 18, January Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Park 21. Signature of Fune Service L 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 A. Pumphrey Funeral Home/ M01305 Part 1. Street the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Read Failura /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause to be a conditional to the cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-tran 05700mpc). Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) led by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 44 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical To the Func within 2 Registrar

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Om s /100

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2002088

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar

0

30. Name and address of person

brew 31. Date filed (Month, Day, Year)

G.

600 N. Wolfe Sheet Balkmore, MD 21287

mpleted cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

M.D

			State of Maryland / D	epartment of F Certificate of I		_	giene () (Reg. No.	Ö	0092	O		
	Physici	an	Decedent's Name (First, Middle, Last) Richard Charles		2. Dete of Death Month Dey Year January 13,2008 8:20 AM							
	/Medic Examin		4e Fecility Name (If not institution, give street end number)	4b. City, Town, or Lo	│ Januar ocation of Deeth			8:20 A	7M			
4	LAdillii	CI	Futurecare at North Point		Eastpo	nint	Ba1	t imor	e Co.			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birth	(In yrs. lest birthday) If Under 1 Year If Under 24 Hrs						oreign		
	Director		190-14-1232 1☑M 2□F 84 Y	Vrs				y, Year) 9. Birthplace (Stete of Country) 19,1923 Pennsy1v				
	۵ ,		Usuel Residence of Decedent						0d. Inside City Li			
	aryle shov	10a. State 10b. County 10c. City, Town or Location										
	Ne M	90	Maryland Baltimore	ore 10f. Zip Code					1 □ Yes 2X	7140		
	with the	눕	10e. Street end Number			10g. Citizen of \						
	23	era	2825 Lodge Farm Road Apt. 431 11. Marital Status 12. Was Decedent Ever in U.S.		1219	:fWN-	United	Stat				
	ter de	Š	11. Marital Status 1	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Blac	ck, White, e				
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21215-0036	within 72 hours after death with the Marylend ene. then "natural; or items 23s or 28s-f show he Madical Examiner must be notified at	Completed by Funeral Director		Decedent's Usuel Occup Give kind of work done	ation		16b. Kind of B	usiness/Ind	ustry			
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pu	el Hygie I other vent, tr	Be	17. Fether's Neme (First, Middle, Last)		18. Mother's Name	e (First, Middle,	Maiden Surnan	16)				
<u>Va</u>	Mentel Merked or	٥	Charles Goodall		Mabelle	Dixon						
Maryland	2 sh end is m			Mailing Address (Street					ŕ			
	1 and 2 Health em 27 i	- 1		825 Lodge F	arm Road				MD 212	!19		
Baltimore,	if ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of t cemetery	Disposition (Name of crematory or other place	:е)	Date	20c. Location -	City or To	vn, State			
ţ	nit. Permen ortant: Injury	Á		Hill Mem.	77-7	.6/2008	Middl	e Riv	er, MD			
Ba	permit. Peges 1 and Depertment of Health Important: if them 27 any Injury or other tr phce.		21. Sign ure of Funeral Service Licensee	22. Name and Addres Duda-Ruck	ss of Facility Funera 1	Home of	Dunda1	k, In	ıc.			
			7922 Wise Ave. Dundalk, Maryland 21222									
			23a. Pert1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between								
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	Examiner		disease or condition resulting in death) a. DYVYYY		<u> </u>							
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	e dae the a	/sic	Pert II. Other significant conditions contributing to death but not resulting in t	he underlying cause give	en in Part I.	23b. Did t	obacco use co	ntribute to	the cause of de	eath?		
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Division	Attending Physician: or deeth. ector: After this certific by the funeral director.	ES	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm			28f. Location (S	Street and Numb	er or Rural	Route Number,			
á	s after i Dire	ert	4 ☐ Homicide determined building, etc. (Specify)	•		City or Tow	m, State)					
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	1041		30. Name end eddress of person who completed cause of death (Item 23e) (To		100	3.10	n ai	000	21001	^		
		1	31. Dete filed (Month, Day, Year) 32. Figistrer's Signeture	akwood	ru c	174 / D	UGA	14/	urroy	2_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 14, 2008 Year **Physician** 01:55 January Margaret Rich Gready /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 13 CF Director 319-30-4308 March 26, 1931 Nebraska 76 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with or items 23a 20817 United States 8021 Rising Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item: edical Examiner n Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No Specify: White 1 ☐ Yes 2 ☐ No Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Henderson Ralph S. Rich ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8021 Rising Ridge Rd., Bethesda, MD 20817 Joseph M. Gready / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Jan. 17, 2008 Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Advess of Facility Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) erebrovascular **Physician** /Medical Due to (or as a consequence of): Examiner Hemorrhagic Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4 □ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2: autopsy performe 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident death hours after deatl uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

DHMH 17 Rev 1/2001

State

Maryland 21215-0036

Baltimore,

0155 AM

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GREADY Or Vital I

MARCEARET,

Division or

Box 68760.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20032. Registrar's Signature

M.D.,

Atul Rohatgi)

31. Date filed (Month, Day,

006301

8600 Old Georgetown Road, Bethesda, Maryland 20814

State of Maryland / Department of Health and Mental Hygiene UU0 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:30 PM INDA GRUBB 08 /Medical 16 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square Rosedale Hospital If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 212-56-7963 1 □ M 2 🗷 F 58 Director West Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "naturel", or items 23a or 28a-f ehow the Mudical Examiner must be notified at £35CX 1 ☐ Yes 2 No Directo MATHRAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21221 W.5A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married rubb, Linda Lee Itimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 No White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry mes Dept. Store and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other treus HCIENA MUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑ Other (Specify) Enton Byon OAKLAWN CEMETERY 19-2008 22. Name and Address of Facility Joseph 2635 Street 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

Immediate Cause (Final disease or condition in death) 21224 Approximate Interval Between Onset and Death Physician Doxemia resulting in death) /Medical Due to (or as a consequence of): Examiner ontine Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed physicien and the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical signed by the attending t be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown been 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has t lirector, page 2 s or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 X Inpatient Director: After this of in by the funeral dir 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Medical Certification; 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij. Hospitel 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cumpletely Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

1 8

08-00378 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raymond Gillespie State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Deat Physician/ Day 2105 hrs Raymond Allen Gillespie Medical Examiner January 13, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Days Min. Director Months Hours 1 V M 07/28/1946 212-44-3818 61 Marvland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location s 23a or 28a-f show e notified at once. 1 Yes 2 V No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 0g. Citizen of What Country 616 Warwick Road 21229 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2 2 No If Yes, Give Year 1968 – 71 specify. Widowed Divorced Yes Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Arthur Gillespie

19a. Informant's Name/Relationship (Type, Print) Ruth Geiss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mardella A</u> Gillespie/Wife Baltimore. Warwick Road 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 V Cremation 3 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Removal from State 1/16/2008 Baltimore, MD Bayview Crematory Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, marle 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 212 **Physician** failure. List only one cause on each line Between Onset and Medical Death a. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial #23a.PII .27 permE.g875 1/23/08 TI IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 V Yes ို 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 neral Director: / filled in by the f Pending 2 Accident Investigation within 24 hours after d To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 14, 2008

2008

who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

on

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January James O. Harmon 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8/26/1923 Birthplace (State or Foreign Country) Months Days Hours Min 84 467-28-7815 Texas Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12813 Falmouth Drive 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWIL Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Vice-President Human Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oran Benjamin Harmon Carrie Ingram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean T. Harmon/wife 12813 Falmouth Dr.; Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 1/18/2008 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Svc.; Silver Spring, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute 30 minutes Due to (or as a consequence f): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1∐Yes 2∐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Ho ify)

Physician /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

Department of Health an Important: If item 27 Is any injury or other trauonce.

Physician

Examiner

Funeral

Director

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or items 23a

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Pages 1 and 2 should

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traumatic event, the Medical Examiner must be

Director

Funeral

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Completed

Be

/Medical

10a. State

MD

be executed and burial-tra physician that the death certificate the as use for igned by the a page 2 s Physician:

Box 68760,

Division or Vital Records, P.O.

Hospital or Attending

certificate | director, this completely filled in by the funeral After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

5 Pending

investigation 6 Could not be determined

Year)

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

31. Date filed (Month, Day,

spital:	1 Impatient	2 🗆	ER/Outpatient	3 🗆 [AOC	Other: 4	□ Nursing H	lome	5 Residence	6 □Other (Specify)	
	Date of Injury (Month, Day Ye	ar)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes		28d.	Describe how inju	ury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Ros City or Town, State)		

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hacl

7305 Baltimore Blud Registrar's Signature

State Registrar

1701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 15,2008 Year 12:37 Carolyn May Harry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day June 8,1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 - M XX Hours 219-38-6484 65 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Jarrettsville MD Harford Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 1628 North Bend Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1 Never Married Married white 1 ☐ Yes 2XXNo Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regina MacDonald Arthur Boemmel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1628 North Bend Road-Jarrettsville, Maryland 21084 William R. Harry, Sr-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1XX Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.18,2008 Baltimore, Maryland 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility 3 Newport Drive EVANS FUNERAL CHAPEL Forest Hill, Maryland 21050 AND CREMATION SERVICES Fredd indiae. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner noumonia Sequentially list conditions, if any, leading to immediate cause. Enter Inc. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes ✓ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes / No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ Inpatient 27. Manner Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Natural 2 Accident Injury 1 ☐ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

the attending physician hed for use as the buria 8004852 P.O. Box 68760 Records, or Vital

Pages 1 and 2 should be filed within 72 hours after

timore, Maryland 21215-0036

the Hospital or Attending hin 24 hours after death. within 24 hours at To the Funeral D

(Check only one)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Challer 500 upper Chesapoake Dr. Bel Air, MO 21014 Vluhamma 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 16 Irma 2008 Humm January 8:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8070 Ventnor Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year May 08 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 M 2 X F 215-12-4279 Director 85 May 1922 MD Usual Residence of Decedent with the Maryland a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 ☐ Yes 2 ☑ No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8070 Ventnor Road r than "natural", or items 23a the Medical Examiner must t 21122 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Charles Margaret Weckesser Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur W. Humm Sr. (spouse) <u>8070 Ventnor Road, Pasadena,</u> MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 2008 21. Signature of Funeral Service 22. Name and Address of Facility ^{Ind Address of Facility} Stallings Funeral Home, P.A. Mountain Road, Pasadena, MD 21122 3111 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one backs on each line. Approximate Interval Between Qnset and Death such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician 101 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home ို 1 ☐ Yes 200 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 □Other (Specify) 27. Manner Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Linatural 1 Tyes 2 Accident the 3 ☐ Suicide 6 ☐ Could not be determined

P.O. Box 68760, Division or Vital Records, al or Attend after death. filled in by within 24 hours a To the Funeral D To the Hospital

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of confile

29c, License number

lress of person who completed cause of death (Item 23a) (Type, Print)

Glen Burnie, MD. 21061 7845 Oakwood Road Ste 106

State Registrar

Medical

31 Date filed (Month

Jorge Miguel Ramierez (Month, Day, Year) 32. Registrar egistrar's Signature

		ľ	For State Registrar		ryland / Depa		Health a	nd Mental Hy	_	8 00933
			1. Decedent's Name (First, Middle, Last)					2. Date of De.		3. Time of Death
	Physicia /Medic		Robert LeRoy Horn	er, Jr.				Januar		08 11:25 A M
1	Examin		4a. Facility Name (If not institution, give s	_		4b. City, Town,		Death	4c. County of	f Death
			Future Care Canton		(la con la sa binde de la	Baltimo		4 Hrs. 0 Date of Bird		O Birtheless (State on Francisco
ŀ	Funeral Director		5. Social Security Number 6. Sex 1215–68–0903	M 2 F	(In yrs. last birthday) 40 Yrs.	Months Days		4 Hrs. 8. Date of Bin (Month, Da 01 / 18 /	Year)	9. Birthplace (State or Foreign Country) MaryLand
			Usual Residence of Decedent		10		1	017107	1507	ALYLANA
	rylan how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	West Va. Grant		Maysville					1 ☐ Yes 2 🔯 No
	ath with the Marylan 23a or 28a-f show	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
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10	fter d	Fu	11. Marital Status 1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No)			in? (Specify Yes or No Puerto Rican, etc.)	Black	, White, etc.
036	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Mudical Examiliner: ust be mullied at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occu kind of work done	pation during most	of working	16b. Kind of Bus	iness/Industry
21	nithin ne. han	ldu	Elementary/Secondary (0-12)	College (1-4or 5+	-)	kind of work done DO NOT use retire	nd)	3	Constant	ahi an
7	iled w tygiei thar ti		17. Father's Name (First, Middle, Last)		Labor	er	19 Mother	's Name (First, Middle,	Construc	
and	d be f	Be C	Robert LeRoy Horner	. Sr.				Elizabeth		,
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationship (Ty)		19b. Mailir	na Address (Street		or Rural Route Number		itate. Zip Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If itam 27 Is markad othar than "naturaf, or Itams any injury or othar traumatic evant, It's Modical Exertines pnce.		20a. Method of Disposition		20b. Place of Dispo			Date		City or Town, State
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Y	*		shock of heart failure. List only or	e cause on each line	he death. Do not ent	er the mode of dyi	ng, such as c	ardiac or respiratory a	rest,	Approximate Interval Between Onset and Death
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	Examiner			Due to (or as a	consequence of):					
	0.00	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
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Вох	attend for us	lan	in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	
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<u>α</u>	The law requires that the ate has been signed by th page 2 should be detache	by Pt	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	bacco use contrib	oute to the cause of death?
rds	w requires that s been signed b should be det							1 🗆 '	′es 2□No 3	3 Nobably 4 □Unknown
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<u>≤</u>	after Dira d in b	Certification;	4 Homicide determined	building, etc.	y - At home, farm, str (Specify)			City or Tov		
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, death	occurred at the ti	ime, date and	place, and due to the	cause(s) and man	ner as stated.
	in 24 ha Fu	edical	(Check only 2 Medical Examir	er: On the basis of e	examination and/or invest.	estigation, in my	opinion, death	occurred at the time,	date and place, ar	id due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	N. 0		29c. Licen:			1	(Month, Day, Year)
				M.0			2213	<i>j</i>	1/17	
	5		30. Name and address of person who co	_				Rathma	. N.	21224
	Sta	te.	31. Date filed (Month, Day, Year)	302 3 32. Registrar	's Signature	r Aver	~	NOTIM	ve 170	21224
	Registr	ar	JAN 10 4	100 Juneary						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Raymond Hofmann 2008 January 14 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, May 10 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 M 2 □ F 88 216-03-3986 Director 1919 MD Usual Residence of Decedent the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? o e 8221 Box Drive 'natural", or items 23a dical Examiner must b 21226 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Utility Company traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of William Hofmann 01ga Wittsburger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau Hannah Brack (daughter) 7807 Harbor Drive, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Loudon Park Cemetery Baltimore, Maryland 2008 21. Signature of Funeral Se vice Lic Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Parr . Enter the east shock, or heart fair re tations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRIAL FIBRILIATION Physician y r disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attencing physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar april Pates

APHILLATEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

3001 S. HAMOVERST, BALPMONE MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician /Medical GERALDINE IOLA HAYES January 2:00 A 2008 16, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD if Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2X T F Director 482-14-3833 87 16, 1920 Pennsylvania Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a 2108 Geneva Place 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier 27 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (mmn) Proud ည Emma Mae Way 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Frank L. Carrington / Son <u> 2108 Geneva Place, Bel Air, Maryland 21015</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of It
Important: If ite
any injury or ot tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Highview Memorial Gran 1-21-08</u> Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009
Approximate 21. Signature of Funeral Service Licenses 23a. Part1. Ent. r the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a construence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine ng physician and as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death signed by the a 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ ate has been sign page 2 should be 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ o 24a. Was an autopsy performed Yes 21 1 Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes npatient P 2 ER/Outpatient 3 DOA this s after death.

al Director: After the 27. Manner of Peath Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🔲 Yes Divisi 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) th (Item 23en) (Type, Print) upper Chesapeake Dr. Bel

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

002538

GERALDINE

32. Registrar's Signature

			For	State of Ma	ryland / I					/	2008	00935
	_		State Registrar			Cer	tificate of L	Jeam	2. Date of De	Reg. No.		3. Time of Death
П	Physicia	an	Decedent's Name (First, Middle, L		. 0 4 7	0 =	^		Month	Day	Year	A 14
	/Medic		4a. Facility Name (If not institution, g		GRAS	27	4b. City, Town, or	Location of Death	JANUAL		2005 ounty of Dear	-
k. -,	Examin	er	14.	SPITAL			-	IMORE				
	Funeral	7.1		Sex 7. Age	(In yrs. last bi	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v Year)	9. Birt	hplace (State or Foreign
	Director		212-36-3858	1 □ M 2 🖾 F	68	Yrs.	WOITHS Days	riouis iviiii.	01-31-	1939		MD
	pu. >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loc	cation					10d. Inside City Limits
	shor shor	ĕ	,				Burnie					1 ☐ Yes 2 ☑ No
	the N 28a-f	Director	MD Anne Anne Anne Anne Anne Anne Anne Ann	runder		Tell	10f. Zip Code			10g. Citize	n of What Co	untry?
	3a or	Ö	224 Poplar Avenu	16			21061			U.S	S.A.	
	ms 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	D- 14	. Race - Ame Black, Whit	
ထွ	after or ite		1 ☐ Never Married 2 Married		lo		☐Yes 2☑No	Specify:		s	Specify:	white
	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	166	Donod	ent's Usual Occup	ation		16h Kind	of Business	/Industry
2	n 72 l "nat edica	ete	15. Decedent's (Specify only highest of	grade completed)		(Give	kind of work done of NOT use retired	during most of wor	king			
77	l withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Ad	mini	istrative	Assista	nt	Co1	lege	
פ	othe vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Nan			urname)	
/lar	Menta	2	Russell Guy					Naomi D				
Jar	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship		1		g Address (Street					
o'	s 1 and of Health item 27 other t		Mr. Frank Ingras	ssia/husbano			Poplar Av sition (Name of natory or other place		Date Dulii		ation - City or	
פֿר	0		1 ⊠Burial 2 □ Cremation 3				n <i>atorý</i> or other plac n Mem. Pá	1	1_2008	Clan	Burni	o MD
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o		4 ☐Donation 5 ☐ Other (Spe- 21. Signature of Funeral Service Lig		Gren							Cremation
Ba	Dep Imp any		X wet K	Flb 110	0304-	_			0			MD 21061
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused	the death. Do	not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a OVAR		-9	CER					Onset and Death
<u> </u>	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):						
	Lxammer	<u>.</u>	Sequentially list conditions,		RATIC a consequence					_		
4/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4	,						
۲	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	e of):			,			
8760,	tte be iysicia ne bur	dical		d								
89	ng ph	Med	IF FEMALE:									
Box	ath ce ttendi or use	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal deal		Ectopic pregnancy Other (specify)	1		23	Bd. Date of de Month	Day Year
O	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	3 L						
٦.	that t ed by detac		Part II. Other significant condition	s contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute t	o the cause of death?
ds	quires n sign ald be	d by	HYPERTENSI	NO					1 🗆	Yes 2	No 3∏F	robably 4 1 Onknown
S	s beer	Completed	TYPE IL DE	LABETES					24a. Was	s an opsy	24b. Were a	utopsy findings available completion of cause of
æ	The la	ome							per 1 Yes	formed?	death? 1 ☐ Ye	
ţ	lan: rtifica	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)		
Ž	hysic his ce	To	Yes 2□ No	Hospital: 1 Inpatie				4 LI Nuising r	Home 5 Res			ecify)
Division of Vital Records, P.O.	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Dat	ry Year) 28b	. Time of Injury	Wor	ryat k? Yes 2 ∐ No	28d. Describe	now injury	occurred	
Sic	death ctor: /	icati	2 Accident investigat 3 Suicide 6 Could not	be 28e Place of init	urv - At home,	farm, str	eet, factory, office	163 2 110	28f. Location	(Street and	Number or F	Rural Route Number,
<u>≥</u>	after Direction by	Certification:	4 Homicide determine	building, et	c." (Specify)		•		City or To	own, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only 2 Medical E)	Physician: To the best caminer: On the basis or	of my knowledg	ge, deat	h occurred at the ti	me, date and plac	e, and due to the	e cause(s) a	and manner a	as stated. ue to the cause(s)
	the Ho iin 24 the Fu	Medical	one)	and manner sta	ated.	2110201111	29c. Licens					nth, Day, Year)
	5 ₩ 6 000 000 000 000 000 000 000 000 000 0	2	29b. Signature and title of certifier	he as	1000	, _			,			
	7		30. Name and address of person w	M. D.		1-1		5000	(J ANI	DARY	16 2008
	10		DEEPTI BAH	2				EET R	ALTIM	ORE	MD.	21225
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	-					,	
	Regist	rar	JAN 1 8 20	08	All p	204	(Second					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Jones ames Koland Jan /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hospita Count beneral Howard 10 Ward (0 lumbia If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 64 Director 217-40-9910 MAY 26 1943 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 X No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a 10087 Windstream Drive, Apt. 1 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ General Manager Tire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be James **Jones** ం Fern Purce11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health and Item 27 is n Victoria Thompson-Jones, wife 4234 64th East, Sarasota, FL 34243 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 TCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/18/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Williams 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final myocardial evation Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9☐Unknown 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: Atter t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar dAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

21

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JOHNSON DIANE N 12:08 AM January 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Baltimore Johns Hopkins Hospital 0 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 3√□F Months Days Hours Min 213-30-2967 Director 7-19-1932 S.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Balto Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1012 Alexander Avenue 21228 US A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after de I Hygiene. Other than "natural", or item Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 9 Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12th grade year marked other Alth and Mental Hve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ew Harvey Stanton Carrie Quick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, James M. Johnson - Husband 1012 Alexander Avenue Balto, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1-18-2008 Balto, MD Druidridge Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BOWEL ISCHEMIA 12 HOURS /Medical Due to (or as a consequence of): Examiner 8 DAYS ESOPHAGEAL PERFORATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an was autopsy performed? 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No Hospital: ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending

death v

Baltimore, Maryland 21215-0036

attending physician peen has certificate

in by the funeral

within 24 hours after death. To the Funeral Director: After this

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

State Registrar

Medical

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Monika Burness, MEDICAL DOCTOR

RES-000

JANUARY 13, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MONIKA BURNESS, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) JAN 1 8 2008 32. Registrar's Signature The John



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** DAVID LEE JOINES January 16, 2008 9:50 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 3232 Old Forge Hill Road Street.
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days Months Hours 1**∑X**M 2□ F Maryland 219-42-6416 62 1945 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21154 USA 3232 Old Forge Hill Road Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 🏖 No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify. ρ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White or than "natura", the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other than any Injury or other traumatic event, the once. 12 Automotive Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Rudolph Patrick Elbert Monroe Joines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3232 Old Forge Hill Rd., Street, MD 21154
a of Disposition (Name of Date 20c. Location - City or Town, State Myrtle Joines / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Ebenezer U.M.C. Cem. 1-22-08 Fallston, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinite untercause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 □Ectopic pregnancy Day in the past 12 months? Month Year ō 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 7 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 1□ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Yes After this 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil

State Registrar

31. Date filed (Month, Day, 8

29b. Signat

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

MYO Ning (h, D.) 602 South Atwood Road # 200 32. Registrar's Signature

2008

M. D

20-12

29c. License number

D45390

29d. Date signed (Month, Day, Year)

January 16, 2008

			For State Registrar	State of M	larylan				lealth a D <i>eath</i>	ind Me		giene/_ Reg. No.	UUO	00940
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea		Vaar	3. Time of Death
Н	Physici		ROBERT SWEIN	TENIODEW.	CD						Month Januar	Day 15.	Year 2008	12:30 P ^M
S. Brigh	/Medic Examin		4a. Facility Name (If not institution, g				4b. City	, Town, or	Location of		Our war		ounty of Death	
	Exami		Hart Heritage				St	reet				Har	ford	
	Funeral			. Sex 7. A	ge (In yrs.	last birthday)	If Unde	er 1 Year	If Under 2		8. Date of Birt	h	9. Birth	place (State or Foreign ntry)
	Director		214-22-3819	M 2□F	80	Yrs.	Months	Days	Hours	Min.	Month, Day June 8			land
	ס		Usual Residence of Decedent											
	ylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Ma-1-	Ş	Maryland Harford	d	Abo	erdeen								1 ☐ Yes 2√∑ No
	r 28	Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. Citize	n of What Cou	ntry?
	h wil	<u>a</u>	217 South Roge	ers				21001				USA	\	
	dea dea	ner	11. Marital Status	12. Was Deceden Armed Forces		.S. 13.	Was Dec	edent of H	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow amplify or other traumatic event, the Medical Examinar must be notified at 00ce.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced]No		1 □ Yes		Specify:	,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	noun, oto.,		pecify:	ite
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g	other,	BeC	17. Father's Name (First, Middle, La	ist)			7 010			r's Name	(First, Middle,			
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Maryland	shound M) —	19a. Informant's Name/Relationship			19b. Mailir	ng Addres	ss (Street			Route Number		own, State, Zij	p Code)
Š	od 2 lith a 27 is r train		Paul A. Jendre	s / Son		217 9	South	Rog	ers. i	Abero	deen, M	D 210	nn1	
ā,	Hea Hean othe	-	20a. Method of Disposition		20b. F	Place of Dispo	sition (N	ame of			ate		tion - City or T	own, State
2	ages int of t: # i		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	cemetery, crei	-			1 -	10.00	D.1 =		
Baltimore,	it. P intme inten injury		21. Signature #Funeral Service Lic		Be.	L Alr I	VIEMOI	TLAL O	Gran ss of Facility	. <u>1</u> –.	18-08	Bet P	ir, Ma	ryland
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			shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.				3 , 000, 00		,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Scr									1 MOS
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		_	Sequentially list conditions,	b. Due to (or a	s a consec	mence of):			_					
	D 10 15	al L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 0	3 4 5571354	140.100 017.								
_	and I-trar	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a conseq	uence of):							-	
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68760,	ortificate be executed ing physicien and eas the burial-transit	edical		d										
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Division of Vital Records, P.O. Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	2 Feta	al death 3[Ectopic Other (ргедпалсу	,			23	d. Date of delive Month	Day Year
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<u>=</u>	The page	Completed									1 ☐ Yes	rmed? 22No	death? 1 ☐ Yes	2 🗌 No
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ב	ng P fter t inera	Ë	27. Manner of eath 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time o Injury	ıf	28c. Injur Wor			28d. Describe f	now injury	occurred	
<u>S</u>	endi eath. or: A he fu	atl	2 Accident investiga				M	10	Yes 2 ☐ N	No				
ž	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place of I	njury - At h etc. (Speci		reet, facto	ory, office		2	28f. Location (3 City or Tox		Number or Rui	al Route Number,
Ω	ital c irs af ral D led ir													
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Check only 2 Medical Ex	Physician: To the best taminer: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tir on, in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	vithin o th	Me	29b. Signature and title of certifier				2	9c. Licens					signed (Month	
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	(X)		30. Name and address of person w		death (Iter	m 23a) (Type	Print)							
	8		BURNAS	SPAMY	6	15	w.	MA	e pu	10:1	Be	101	n, M	0 21014
	Sta Registi		31. Date filed (Month, Day, Year)	127	strar's Signa	A A	A CONTRACTOR OF THE PARTY OF TH							

DHMH 17 Rev 1/2001

State
Registrar

201-109

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramed Salapathi

31. Date filed (Month, Day, Year)

Back River Neck Road baltmore Maryland 21213

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** January 14 2008 Wonsik Kim 7:30 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 7885 Gordon Court Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 004-82-7532 79 Director 03/04/1928 South Korea Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Glen Burnie Anne Arundel 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7885 Gordon Court 21060 U.S. Resident Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian ₽ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Taelin Kim Gannan Pyo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chun Kim Son 9611 Washington Blvd., Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park 01/16/2008 Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 Part 1. Enter the diseas of conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of y the cause on each line. Approximate Interval Between Onset and Death Im Tediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Due to (as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetai death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury al or Atternations after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Rolling RD Ballo MD 2118 endery 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Er	nsure All Copies Are Legible.
State of Maryland / Department of Heal	th and Mental Hygiene
Certificate of Dea	ath Reg. No. 2
(First, Middle, Last)	Date of Death Month Day Year
Jacob Henry Konopka	Januart 11 2009

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	•	For State Registrar				rtificate of			Reg.	000	annala
Physici		1. Decedent's Name (First, Middle	, Last) Jacob	Henry	, K	onopka			Date of Death Month January	Day Year 11,2008	3. Time of Death 5:27 P
/Medic Examin		4a. Facility Name (If not institution	, give street and number			4b. City, Town, o	or Location of		dildary	4c. County of Dea	
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Funeral Director		219-30-5301	6. Sex 7. A 1X M 2 F	ige (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min	Date of Birth (Month, Day, Ye 19. 20,	ear) (rthplace (State or Foreign country) aryland
and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation					10d. Inside City Limits
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r 28a	Director	10e. Street and Number	ICIMOLE			10f. Zip Code			10g	. Citizen of What C	country?
h with	<u>a</u>	1923 Merritt	Blvd.				21222			United S	States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are sent in the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ange.	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Deceden Armed Forces ied 1 ☐ Yes 2.K	t Ever in U.S. ?] No		Was Decedent of H		in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Wh	
ari, o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 □ Yes 2Ñ No	Specify:			Specify:	White
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shoul ind M ind M	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Number	r or Rural R	oute Number, C	City or Town, State,	Zip Code)
and 2 ealth a n 27 ls		Mr. Herman Kon	opko (Broth	er)	720	8 Birch	Ave.	Dunda.	lk, Mar	yland 21	L222
Pages 1 and of He		20a. Method of Disposition 1 IX Burial 2 ☐ Cremation		eı		osition (Name of matory or other pla theran Co	1	Date		c. Location - City o Dundall	
nit. P artme ortan injur		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		CIILLS	2	2 Name and Addre	nee of Eacility				
permit. Departr Importa any inji		Honor	8 Jen	X		Duda-Ruc 7922 Wis				Dundalk, Maryland	
		23a. Part1, Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. I	Do not en	ter the mode of dyi	ng, such as o	cardiac or re	espiratory arrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	At	heros	cler	otic He	art	Dese	ais		Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	s a consequen	ice of):	otic He					
Zammer	-	Sequentially list conditions,	D	s a consequen		0512					
nsit A ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Bue to (or a	a consequen	100 017.						
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Attending Physician: The law requires that the death certificate refacth. rdeath. ector: Attent his certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnanc 2 ☐ Fetal de at time of deat	eath 3[☐Ectopic pregnand ☐ Other (specify) _	ey			23d. Date of d Month	elivery Day Year
that thed the		Part II. Other significant condition					ven in Part I.		23e. Did tobac	cco use contribute	to the cause of death?
quires n sign ald be	d by	Coronary a	stery Dise	ast 5	1P	CABG			1XYes	2 No 3 1	Probably 4 □Unknown
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hysician: The law his certificate has to director, page 2 s	ပ္ပြဲ	Chronic o	Bspuctive	2 Pul	non	ary Dis	ease		performe 1□ Yes 20	d? death? KNo 1 ☐ Ye	
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or Attending Ph after death. Director: After th I in by the funeral	cation	1 Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	g (Month, E	Pay Year)	Injury	M 1	Yes 2 N	10			
al or At s after d	Certification:	4 Homicide determi	: Zoe, Place Ul II	njury - At home etc. <i>(Specify)</i>	e, tarm, st	reet, factory, office		28f.	City or Town,		Rural Route Number,
e Hospital or Attendin 124 hours after death. The Funeral Director: Af pletely filled in by the fur	dical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the bes Examiner: On the basis and manners	of examination	edge, dea n and/or ir	th occurred at the to	ime, date and opinion, deat	d place, and th occurred	I due to the cau at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
01/14/2008 29c. License number 20011150

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MGCITO M - TORRES, MO 441 5. ELL wood AUE, BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

JAN 1 8 2008

Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician JANUARY** ANNA JENKINS KAHOE 16, 2008 8:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center @ GBMC Baltimore Towson If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🔀 F Maryland Director 1924 219-18-0267 83 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ıral", or items 23a or Examiner must be r 710 Idlewild Road 21014 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after of Hygiene.

Other than "natural", or itel ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by If Yes, Give Year or Dates: 3√2 Widowed 4 □ Divorced White Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be ' Department of Health and Mental important: If item 27 Is marked o Ignatius Walter Jenkins Sr. Anna Augusta Webster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Winter Camp Trail, Hedgesville, WV 25427
ace of Disposition (Name of Date 20c. Location - City or Town, St John W. Kahoe / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Ignatius Cath. Chr. 1-21-08 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier January 16,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 6 Binc Rilay 6701 N. Ch. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2-Date of Death Day **Physician** Richard Nevin Kerr ANUARY 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CLEN BUKNIE Anne HEIMIRE WARMINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Mar. 24, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 213-28-2051 ^{Ye}1932 1 M 2 □ F 75 Mary Tand Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1402 River Mist Court 21226 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Tyes 2 1954-If Yes, Give 1954-Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 2 3 X Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Kerr Catherine Stromberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Metzger/Son in law 1400 River Mist Court Curtis Bay MD 21226 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Crestlawn Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01-17-2008 Marriotsville, MD 4 □ Donation 5 TXOther (Specify) entombment Gardens Andress of Facility
Androse Funeral Home, Inc.
1320 Sulphur Spring Rd. Arbutus MD 21227 21. Si mature of Funeral Service Licensee 23a. Parti. Enter the disease, or comprications that caused the death. Do to tenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GACTROINTESTINAL Physician /Medical Due to (or as a consequence of) Examiner SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate I 1∐ Yes 2 No Division or Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2√No မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. I Director; / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature MO ane and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Burne (en 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

			State of Manuard / Doe	artment of Health and Men	•	
				rtificate of Death	,	inna nnal.c
			Decedent's Name (First, Middle, Last)		Reg. Né: ate of Death	3. Time of Death
	Physici /Medic		Ida Florene Laker	J ^A	an Day	7 2008 9:30A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
			Gensis- Loch Raven 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Parkville If Under 1 Year If Under 24 Hrs. 8 D	altimore (Change	
ŀ	Funeral Director		218-09-3192 1□M 2XIF 87 Yrs.	Months Days Hours Min.	ate of Birth Month, Day, Year) 2 / 05 / 19	9. Birthplace (State or Foreign Country) 20 Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary I sho	to	MD. Baltimore Nottin	ngham		1 ☐ Yes 2 No
	th the or 288	Funeral Director	10e, Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
	ath w	ral	9468 Seven Courts Road	21236		SA
	ter de Irer	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ∑ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	 Race - American Indian, Black, White, etc.
036	eal', or	by	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2X No Specify:		Specify: White
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102	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First	st, Middle, Maiden	Sumame)
/lar	uld be Menta Irkad Itic ev	To B	George Grimm	Helen M.	Myers	
Mar.	l 2 sho and I Is ma			ing Address (Street and Number or Rural Rou		
e,	1 and Health em 27			Seven Courts Rd.		ngnam, MD 21236
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Madical Examinant the notified at once.		IANDUNAL Z CHEMIATON S CHEMIOVALIUM STATE	osition (Name of matory or other place) 01/21/	0.8	kville, MD.
ati	permit. Departm Importa any inju				bal and	Cromation Syc
_	80 E 29		Mully No Vaus 18	2 Name and Address of Facility Vans Funeral Char 800 Harford Rd. F	arkvill	e, MD. 21234
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760,	eath certificate be executed attending physician and for use as the burial-transit	calE	d			
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Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy	2	23d. Date of delivery Month Day Year
o.	the de y the a	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Pulling of death 5 Unknown	Other (specify)		
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Records,	ne law r has be je 2 sh	Completed			4a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital F	ysician: The is certificate hadirector, page				performed?	death? 1 ☐ Yes 2 ☒ No
	ysicia s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Chent 3 DOA Other: 4 Nursing Home		3 □Other (Specify)
0	ng Phys ter this neral di		27. Manner of Death 1 ★Natural 5 Pending (Month, Day Year) 28b. Time of (Month, Day Year)		Describe how injury	
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Division of	To the Hosuitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide		ocation (Street and lity or Town, State)	d Number or Rural Route Number,)
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	- 6		30. Name and address of person who completed cause of death (Item 23a) (T. pe,		Jai	1, 17000
_	۵		MADUTION 674 NEW	Print)	Datti	mil 2100%
	Sta Registra		31. Date filed (Month, Day, Year) JAN 18 2008 32. Registrar's Signature	and a		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Print 1:em 29d per doc 8875 1-18-08 vt.
State of Maryland? Department of Health and Mental Hygiene

AMEND TIEM/2, per HYS criticale of Death

Reg. N. 2 0 0 8 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12-25AM Jon YICHAEL LOCKE 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson
If Under 1 Year | If Under 24 Hrs. St. Joseph's Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Days 1 X M 2 □ F Months Hours Director 195-34-6032 60 01-14-1947 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exeminer met Lemotified at 1 Yes 2 No Director MD Elkridge Howard 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code United States Itams 23a 6038 Hunt Club Road 21075 death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should ba filed within 72 hours after of and Mental Hygiene. Is markad othar than "natural" or Itar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٥ Boyd W. Locke Alice Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 item 27 Julia Locke - wife 6038 Hunt Club Road, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State parmit. Pages of Pepartment of Himportant: If ite any injury or ot once. 1 ☐ Burial 2 Tremation 3 ☐ Removal from State January `4 ☐ Donation 5 ☐ Other (Specify) 9, 2008 Metropolitan Crematory Catonsville, MD 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATHEROSCLEROSI ORONARY rear disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Obstructive Pulmonay Disco The law requires that the death certificate be axecuted as the burial-transit monic that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Morbid Obeni IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Junknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ 2 □ No 24a. Was an autopsy performed? 20No 1 Yes of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 2. ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sup Le MD D003513V 10000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Santiago Rd Columbus 21045 0, Supt S 32 Hegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

				State of M						•	•	00010
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		- 1	Decedent's Name (First, Middle	, Last)					2.	Date of Deat	h	3. Time of Death
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	Examir		4a. Facility Name (If not institution)			vn, or Location o			4c. County of De	
	**		Harford Memor	-				de Grac			Harford	
	Funeral Director		5. Social Security Number 506-74-9896	6. Sex 7. Ag 12℃ M 2 ☐ F	ge (In yrs. I 55	Yrs.	tf Under 1 Y Months D	ear If Under ays Hours	Min.	Date of Birth (Month, Day, 1 ,	^{year)} 1952 Co	Birthplace (State or Foreign Country) Lorado
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. In side City Limits
	Mary -feh	ţ	Maryland Harfo	5ee	7 hor	rdeen						1 ☐ Yes 2X No
	h the	Director	10e. Street and Number	Lu	TAUC.	Laccii	10f. Zip Co	de	-	1	0g. Citizen of What	Country?
	th wit	alD	3849 West Chap	el Road			2100)1			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.1	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Specify	y Yes or No-	14. Race - Ar Black, WI	merican Indian,
21215-0036	within 72 hours after death with the Maryland jiene. r than "natural", or Iteme 23a or 28a-f ehow the Medical Examinat must be notified at	ρ	1 Never Married \$ Married 3 Widowed 4 Divorced	ed to Yes 2 [] If Yes, Give Year or Dates:	No	1	l∐Yes 2,€				Specify:	White
7	n 72 h	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	tent's Usuat O kind of work d	one during most	t of working		16b. Kind of Busine:	ss/indu <i>s</i> try
12	within ene. then	E G	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use re	,	E		II C Corro	amount.
d 2	Tr. Hyge		17. Father's Name (First, Middle, I	4		Spec1	ar wea <u>r</u>	ons Off			U.S. Gove	riment
an	o g g o	To Be	Samuel Stanley	Lantzer							cMullen	
Maryland	동민보통	-	19a. Informant's Name/Relationsh			19b. Mailir	g Address (St				City or Town, State	, Zip Code)
	1 and 2 : Health ar tem 27 is		Laura E. Wrenc	n / Wife		7533	East Hu	abbell S	St., S	cottsd	ale, AZ 8	5257
ore,	of Healt of Healt rother		20a. Method of Disposition	n	20b. PI	lace of Dispo	sition (Name o	of place)	Date		20c. Location - City	or Town, State
Ē	0 0		1 Surial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		'			ı	n. 2-2	8-08 A	rlington,	Virginia
Baltimore,	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service I	icensee				ddress of Facility Funeral				
_	20539		Nesky 1	1.1/hughs		1	317 Col	cesbury	Road.	Abina	don, Mary	land 21009
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										Approximate tnterval Between On set and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	-a Meh	ash	stic	chi	Sur	on's c	overin	aura	Onset and Death
	/Medical Examiner		is a data,	Due to (or as	a consequ	rence of):		V				
	¥	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	а солѕеди	ierice of).						
6	sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	e exec en an irial-ti		resulting in death) Last	Due to (or as	a consequ	ience of):						
	9 % 9	IIcal		d								
x 68	entific ling p	Mec	IF FEMALE:									11
Вох	death certificate e ettending phy of for use as the	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregn				23d. Date of o	delivery Day Year
P.O.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	t time of de	atn 5	Other (specif)	v)				•
۳.	The law requires thet the death Ne has been signed by the etter Dage 2 should be detached for i	4	Part II. Other significant condition	ns contributing to death b	out not resu	ilting in the ur	iderlying cause	given in Part I.		23e. Did tob	acco use contribute	to the cause of death?
rds	w requires that been signed to should be deta	Q D	Conous	my on le	y,	die	o el			1 🗌 Ye	s 2 110 3 1	Probably 4 Unknown
O _O	s bee	lete							Ī	24a. Was a	n 24b. Were	autopsy findings available
Vital Records,	The law sete has page 2 s	E		-				1		autops perform	y prior t ned? death	o completion of cause of ?
ital		Be C	25. Was case referred to medical					26. Place	of Death #C	1 ☐ Yes 2 Check only on		es 2 No
of V	S & D	70 E	examiner? 1 ☐ Yes 2 ☐ 170	Hospitat:	ent 2	R/Outpatien	3□ DOA	Other			nce 6 □Other (S)	pecify)
0	ng Pi	Ë	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time of Injury	28c.	Injury at Work?			w intury occurred	
sio	Attending r death.	catl	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation				1 Yes 2 N				
Division	al or At s after of it Directed in by	Certification:	4 Homicide determine		iury - At hor ic. <i>(Specify</i> ,	me, farm, stro	et, factory, off	ice	281.	City or Town		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best examiner: On the basis of and manner sta	it examinati	wledge, death ion and/or inv	occurred at the	ne time, date and my opinion, deat	d place, and th occurred a	due to the ca at the time, da	use(s) and manner ate and place, and d	as stated. lue to the cause(s)
	To the comp	M	29b. Signature and title of certifier				29c. Lic	ense number		25	d. Date signed (Mo	nth, Day, Year)
			1/1/1/	Contec			0	4780)4		0//16/	2000
	1241		30. Name and address of person v		leath (Item	23а) (Туре,	Print)				01/16/ MD	
	10		A. MOUI	12c 16	Abe	wee	- Pla	re A	Olevo	Ren	MD	71001
	Sta Registra		31. Date filed (Month, Day, Year)	32 Registr	ars Signati	ure	A. D.					
	100000		.IAN 18	LUUO KARKAR	D Set	15 de 10	-0 C					

Edward Bruce Mosley

J			
State of Maryland /	Department of He	ealth and Menta	al Hygiene

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		1- For State Registrar Ce	rtificate d	of Death)		Re		00 0094
Physicia	n/	Decedent's Name (First, Middle,Last)					2. Date of Death Month	1	3. Time of Death
ledical Examin	ner	Edward B. Mosley					January 14	, 2008	1021 hrs
2		4a. Facility Name (if not institution, give street and number)				ation of Death		4c. County of Dea	ath
		11 Redwood Circle		Hager				Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Unde Months		Under 24Hrs Hours Min	_	h(MM/DD/YYYY) 9. E	oian
Director		218-12-6337 1×M 2 F 8	6 Y	rs.] 50,0		10/2	1/1921	Country) Va
÷	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loc	ation					10d. Inside City Limits
ow any				allon					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ģ	MD Washington Fa	irplay	10f. Zip	01-		Lac	og. Citizen of What Co	
th the Maryland 23a or 28a-f sho notified at once	Director	Toe. Street and Number						•	ounity?
ith th		7910 Fairplay Farms Rd 11. Mantal Status 12. Was Decedent Ever in U	18 12 1		733	o Osiois 2 / Co	pecify Yes or No-	USA	erican Indian, Black,
ath w items	uneral	1 Never Married 2 Married Armed Forces?				xican, Puerto		White, etc.	
ter de	<u>ا</u> ۳	1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year	1	Yes 2	X No so	ecify:		Specify: W	ni to
urs af itural	a p	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual (Occupation (Give kind of		16b. Kind of Busines	
5 72 ho n "na al Ex	eţe	Elementary/Secondary (0-12) College (1-4 or 5+)	during	most of work	ing life. DO	NOT use ret	red)		
5-0036 Jed within 7 Hygiene. I other than	Complete	4	Mec	hanic				Automoti	ive Dealer
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last)			18.N	lother's Name	e (First, Middle, M	laiden Surname)	
121 d be fi ental arked	B	C. H. Mosley					Melton		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relationship (Type, Print)	- 1					ber, City or Town, Sta	
y, MD 21215-0036 and 2 should be filted within 72 fealth and Mental Hygiene, tem 27 is marked other than 'traumatic event, the Medical	-	William G. Merritt/Nephew 20a Method of Disposition 20b.	Place of Disp				Forest	Hill MD 2	
Baltimore, Normit. Pages I and Department of Healt Important: If item	-1	1 X Burial 2 Cremation 3 Removal from State	crematory or		e or cernere			200. Education - Gity	or rown, state
tim L. Pag tment rtant:			0aklaw				/21/08	Baltimo	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other traumatic event, the Med		21 Signature of Fun val Service Licensee		. Name and A				Funeral H	
Physician	-	23a. Part I. Enter the disease, or complications that caused the death						am MD 212	.36 Approximate Interval
/Medical		failure. List only one cause on each line.		110 1110 00	aying, out	. 45 54.4.40	r roopiratory arre	or, one or, or noun	Between Onset and Death
taminer	1	Immediate Cause (Final disease or condition resulting in death) a. Intraoral Gunshot Wou Due to (or as a consequence of					_		
	-	Sequentially list conditions, b	,						
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause	of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	of):						
ecuted and - transit		d							
al al	Medical	UNPENDED							
		IF FEMALE: 23c. If yes, outcome of preg 23b. Was decedent pregnant in the	gnancy					23d. Date of deliv	ery
Sox 687 death certific e attending for use as t	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of d	ooth	Fetal death		ctopic pregna	ancy	Month	Day Year
Box e death c the atten	Şi	1 Yes 2 No 9 Unknown 9 Unknown	eath 5 (Other (Spec	rfy)			0.420	
Che the	Phy	Part II. Other significant conditions contributing to death but not	resulting in the	underlying	cause giver	in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ires that	d b						1 Yes	2 🗸 No 3 🔝 P	robably 4 Unknown
ords,	ete						24a. Was a		autopsy findings available to completion of cause of
e CO ne law te has	Completed						perfor	med? death	
		25. Was case referred to medical		2	6.Place of [Death (Check		2 No 1	res z No
of Vital Records, ng Physician: The law require then this certificate has been sineral director, page 2 should be	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 Do	Oth	era Nursii	ng Home 5	Residence 6 🗸 Ot	her: Scene
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification in the funeral director.		27. Manner of Death 28a. Date of Injury	28b. Time o	f Injury 2	8c. Injury at	Work?		now injury occurred	
Division tall or Attendin is after death.	[뜵	1 Natural 5 Pending Jan 14, 2008	0957 hrs		1 Yes	2 🗸 No	Subject sho	t seit	
ViS or At fter d Direct in by	<u></u>	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, str	eet, factory,	office buildi	ng, etc.	28f. Location (S or Town, S		Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: rtely filled in by the:	Certification:	4 Homicide determined (Specify) Single Far	nily				11 Redwood (Circle, Hagerstown	, MD
To the Hos within 24 h To the Fun completely		29a. Certifier 1 Certifying Physician: To the best of my knowled (Chack only one)						. ,	
To the within 2 To the complet	Medical	and manner stated.	and/or investig				at the time, date		
	2	29b. Signature and title of certifier		29c.	License nu			29d. Date signed (f	
	L	My una plasself, 111)			O.C.M.E			Jan∪ary 15, 20	
12		 Name and address of person who completed cause of death (Iter Melissa Brassell, MD Assistant Medical Exami 		Penn Str	eet Ralti	more, MD	21201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signat			oct, Daiti	THOIG, IVID	_ 12U I		
Registr	_	JAN 1 8 2008	Re B	Bad Const					
	_	7	29						

			a FOI	Department of Health and	Mental Hygien	ne
			1 - State Registrar	Certificate of Death	Reg. N	10.2008 00950
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Oay Year
	/Medic	al	Helen Moravec	41. Cit. Town and position of Doub	10000	3 2008 832 M
	Examin	er	4a. Facility Name (If not institution, give street and number) Howard County General Hos	4b. City, Town, or Location of Dear	mı	4c. County of Death
χ.	Funeral	*	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		350.16.6046 10 M 2 WF 8	Yrs. Months Days Hours Min.	(Month, Day, Yea	24 Country)
3	pr ,		Usual Residence of Decedent			
	arylar show d at	-		own or Location		10d. Inside City Limits 1 ★ es 2 □ No
	he M 28a-f otifie	Director		Port Richey	10-6	Ditizen of What Country?
	a or		10e. Street and Number	10f. Zip Code		
	eath ns 23 musi	eral	6105 Cortez Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	34653 13. Was Decedent of Hispanic Origin? (\$		S . A .
0	ifter d ir iten	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	If Yes, specify Cuban, Mexican, Puel	to Rićan, etc.)	Black, White, etc.
<u></u>	ral", o	by	3 Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
2-003p	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 10 (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
7	vithin ne. han '	mp	Elementary/Secondary (0-12) College (1-4or 5+)	Ione Maker	I	wn Home
7	iled v Hygie ther t nt, th		12 17. Father's Name (<i>First, Middle, Last</i>)		me (First, Middle, Maide	
au	0 70 0) Be	Joseph Krupa		e Dlugopo	,
<u></u>	2 should be and Mental Is marked or raumatic ev	ပ္		9b. Mailing Address (Street and Number or R		y or Town, State, Zip Code)
Z	nd 2: alth al 27 Is r trau		Linda Hillard/daughter	650 Smokey Wreath	. Wav Ell	21042 Licott City. MD
ē,	item	-	20a. Method of Disposition 20b. Place	of Disposition (Name of terry, crematory or other place)	Date 20c.	Location - City or Town, State
altimor	Page nent c int: If				17.08 Bel	ltsville, MD
Dalt	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic er once.		21. Signature of Funeral Service Licensee M01443	22. Name and Address of Facility CA	FA/Stephe	en D. Lohrmann, PA
			23a Part 1 Enter the disease or complications that caused the death. D	8717 Green Past		Approximate
	D 1		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.			Interval Between
	Physician /Medical		disease or condition resulting in death) a	eless tleck	ical A	chirty 10 minutes
	Examiner			TN		'
Ţ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ee of):		
	ecute ind trans	Examiner	that initiated events c.			
Š,	cate be executed physician and the burial-transit	E	Due to (or as a consequence	e or):		
00/00 00/00	icate physi the	dical	d			
XO2	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
ň	death a atter	iciar	in the past 12 months? 1 Ves 2 Male 4 Pregnant at time of death			Month Day Year
j.	t the o	hys	9 Unknown			
ν̈́.	ss tha gned	by P	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
5	equin en si ould I	ted			1 Tyes	2 No 3 Probably 4 Munknown
Records,	law ras be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	The	5			performed? 1□ Yes 2 🖼	? death?
N I G	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Other	ath (Check only one)	
5	Phys this ral dir	2	1 Inpatient 2 NEH/		fome 5 ☐ Residence 28d. Describe how in	
	Attending r death. ector: After by the fune	ion	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	o. Time of lnjury at Work? M 1 □ Yes 2 □ No	20d. Describe flow in	july occurred
UNISION	Atten deat actor	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home,		28f. Location (Street	and Number or Rural Route Number,
5	s after	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) 1			
	o the	Mec	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
3	⊢≯⊢ŏ		Mark Kha n	9 0003802	6 7	2040CZ 14 7408
,	in		30. Name and address of person who completed cause of death (Item 23a		1	7,200
	IU		Mark King 15755	ce dar lane	Columb	ia MD. 2/144
	Sta		31. Date filed (Month, Day, Year) JAN 1 8 2008 32. Régistrar's Signature	(South		
	Registr	ar	JAN 1 8 2008			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Vlagee Jan 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hella Pice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 1 F 215-16-9921 Usual Residence of Decedent 85 Director June 15, 1922 Maryland death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Show iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Baltimore Directo Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Place 212360 USA Junhaven Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: white Completed by 3 NWidowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Pages 1 and 2 should be filed within than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Homemaker 6 wn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kwiatkows ပ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mueller-daughter 5 Dunhaven Place Apt 76 Nothingham MD 21236

Date 20c. Location - City or Town, State ratricia Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislavs
Cemetery 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-18-2008 Dundalk, 4 ☐ Donation 5 ☐ Other (Specify) WD 22. Name and Address of Facility
Evans Funeral Chapet & Cremation Services Parkville
8500 Harford Road Parkville Md 21234 21. Signature of Funeral Service Licenses Stace of N Varti Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6012 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): attending physician for use as the buriar P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2**K** No certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

EDDIE NAKHUDA

31. Date filed (Month, Day,

JANUARY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 16, 2008 0403 Edward J. Mueller, Sr. January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard <u>3717 Saint Johns Lane</u> Ellicott City B. Date of Birth (Month, Day, Year) 07/03/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 XM 2 ☐ F 84 212-20-5263 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10h County 1 ☐ Yes 2 No Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3717 Saint Johns Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 44 - 46 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank J. Mueller, Sr. Anna Eugenia Reuttinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12824 Lanes Run Road Big Pool, Maryland 21711 Edward J. Mueller, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery 20a, Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 01/21/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAD 30 grs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 200 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Jermit. Pages 1 and 2 should be be bepartment of Health and Merimportant: If item 27 in any injury or certain. **Physician** /Medical Examiner the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ıral", or items 23a or 28a∙f shov Examiner must be notified at

death v

ld be filed within 72 hours after de ental Hygiene. ked other than "natural", or item ic event, the Medical Examiner r

Mental

traumatic event.

Saltimore, Maryland 21215-0036

O. Box 68760,

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Division or Vital Records,

Director

Funeral

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Completed

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Examine attending physician and for use as the burial-transi Physician/Medical led by the a signed by the detact ð Completed peen page 2 s Be P spital or Attending Phy nours after death. neral Director: After this / filled in by the funeral d Certification:

has

certificate

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 ☐ Yes 💇 No 27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be determined

VICTOR MADRID

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

28c. Injury at Work? 1 Yes 2 No

2028024Co

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

CATONSVILLE

29a, Certifier

◆ Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

700 65784 120

State Registrar

Medical

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral C Hospital

Trene MOBGVEFO Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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/Medic		MOGAVERO,		- RE	NE			JANUAR	1 15th 200	
Examin	er	4a. Facility Name (If not institution, g		• •			or Location of Death		4c. County of	Death
	4	Baltimore Washir 5. Social Security Number 6			nter as <i>t birthd</i> ay)	Glen Bu	rnie If Under 24 Hrs.	9 Date of Bir	Anne An	
Funeral Director		212-36-1721	1 M 2 M F 7. Ag	68 68	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	22 ear) 15 .1939	Birthplace (State or Foreign Country)
		Usual Residence of Decedent		- 00				APLIL.	13,1939	MD
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ith th or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	1927 Arundel Roa				21122			U.S.A.	
er de items ner m	nne	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Black,	American Indian, White, etc.
rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	NO		1 □ Yes 2 ሺ No	Specify:		Specify:	White
thou atura	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/Industry
nin 72 n "n: Media	plet	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give life.	kind of work done DO NOT use retire	during most of work d)	ing		,
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al Hy I othe vent,	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle	, Maiden Surname)	
Ment Ment arkec	2	Jacob Bonnett					Irene B	 Swede 	r	
2 short and is m	П	19a. Informant's Name/Relationship							er, City or Town, Sta	ate, Zip Code)
and lealth m 27 her tr		Mr. Joseph Moga	vero/Husbar				Road Pasa			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	CE	emetery, cre	osition (Name of matory or other pla		19,	20c. Location - Cit	
t. Pa rtmen tant: njury		4 □ Donation 5 □ Other (Spe		Lou		ark Cemet			Baltimor	•
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the g	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4⊟Pregnant at 9⊟Unknown	time of de	eath 5L	Other (specify) _				,
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ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry y Year)	28b. Time of Injury	f 28c. Inju	ry at rk?	28d. Describe	how injury occurred	
tendi eath. tor: A	cati	2 Accident investigati 3 Suicide 6 Could not	he				Yes 2 □ No			
or At fter d Direct in by	Certification:	4 Homicide determine				eet, factory, office		28f. Location (City or To	Street and Number own, State)	or Rural Route Number,
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To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	f examinat	ion and/or in	vestigation, in my	opinion, death occur	red at the time,	, date and place, and	d due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (f	Month, Day, Year)
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20	-	30. Name and address of person wh	were !	. —	23a) (Type,	Print) Dr.]	Donna Eve	rsley M		
2	_	7845 OAKWOOD	ROAD S	VITE	204		BURNIE	MÓ	2106	01
Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture	land.				
Registra	ir	JAN 1 8	2008	ARD 6	AS A	A STATE OF THE PARTY OF THE PAR				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:04 PM M Frederick E. Meister Jr 2008 January 3, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 213-26-1137 78 Director Oct 10, 1929 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at r 28a-f sh notified 1 ☐ Yes 2 ☑ No Carroll Director Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 2310 Susanann Drive 21074 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced **'**48-52 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor elevators 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Edwin Meister Sr Lillian Margaret Lotsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Margaret Meister/spouse 2310 Susanann Drive Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 □ Other (Specify) 21. Sig arme of Funeral Service Licen Rop Id S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director ane Baltimore, MD 21201 t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Souse (Final disease or condition resulting in death) Physician oronary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 MUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1 ☐ Yes 2□ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier Highway N. 6# Glen Burnie 701) 30. Name and address of person who se of death (Item 23a) (Type, Print) YEONG 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Examiner death certificate be executed burial-trar P.O. Box 68760, physician the. nding as Ise for ed by the a signed b Division or Vital Records, page 2 should certificate has Physician: funeral director After this Hospital or Attending within 24 hours after death To the Funeral Director:

Director

28a-f show la or 28a-f sh t be notified

23a

or items

"natural", or item: ledical Examiner n 72 hours after

raumatic event, the Medical

Physician

/Medical

3altimore, Maryland 21215-0036

Certification: To

6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD Trimble Hill CT. Latherville MILLTELLO 6 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

filled in by

completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 9:02 A M PAVINSKI 15 JANUARY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY
If Under 1 Year If Under JOHNS HOPKING HOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 1**M** M 2□F Days Pittston, 181-36-2300 Usual Residence of Decedent Feb. 12,1946 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Izerne 10f. Zip Cod 10e. Street and Number 10g. Citizen of What Country? 1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any injury or other traumatic event; the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Funeral

Director

1 - For State Registrar

DONALD

10a. State

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit DiVision or Vital Records, P.O. Box 68760

ā	31 Drowncrest Drive		18644.		USA	
Inel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was E	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame Black, Whit	
Ī	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		es 2 No Specify:	, , , , ,	Specify:	
Be Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				Specify. W	hite
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Ö	12	-abar	~		enstruc	Mon
	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Mai	den Surname)	
은	Edward Pavinski		Mary	1011	++	w
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Add	dress (Street and Number or F)	ıral Route Number, C	ty or Town, State,	Zip Code)
	Doreen Pavinski-Spouse	3/1/21	owncrest Di	ve, West	Wyomia	79 PH 18644.
	20a. Method of Disposition 20b. Plac	e of Disposition etery, crematory	(Name of or other place)	Date 200	:. Locati∳n - City or ∕I	Tovljn, State
	4 Donation 5 Other (Specify)	eter+ ra	il Cemetery JAN	1. 14,2008	voca.	14
	21. Signature of Funeral Service Licensee	22. Nam	ne and Address of Facility	d. BALTIN	norE, MC	521234.
	skillerly (b. saw)old		Funeral Chapt	21+ (remati	on Service	s-Parkville
	23a. Pa 1. Enter the dis so, complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the	mode of dying, such as car lac	or respiratory arrest,		Approximate Interval Between
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Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting	og in the underly	ing cause given in Part I	23a Did tobac	no usa contributa t	o the cause of death?
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ed.				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, fa	ictory, office	28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
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cal	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination	dge, death occu and/or investig	irred at the time, date and place ation, in my opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Medical Certific	one) and manner stated,					
2	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mon	th, Day, Year)
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	30. Name and address of person who completed cause of death (Item 23	, , , , , ,				
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State

Registrar

31. Date filed (Month, Day, Year)

(234/2)

32 Registrar's Signature

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	/Medic			Jungui	Park		4h Cihi Taum an	Leastien of Dog	Janua		2008 ounty of Death	1:00 P
	Examin	er	4a. Facility Name (If not institution Lorien Nursing		,		4b. City, Town, or		atri	40.00	,	
	Fundadal		5. Social Security Number	6. Sex		. last birthday)	Colum If Under 1 Year		rs. 8. Date of Bi	rth	Howar 9. Birthr	nace (State or Foreign
l	Funeral Director		150-84-1602	1 ∑ M 2□F	66	Yrs.	Months Days	Hours Mir	n. (Month, D 05-01-		Cour	orea
17			Usual Residence of Decedent						_ 05 01	1741	1	OLG
	inylan ihow Lat	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	10d. Inside City Limits
	e Ma Ba-f s	cto	MD H	oward			Woodstoo	:k				1 ☐ Yes 2 No
	or 2	Director	10e, Street and Number				10f. Zip Code			10g. Cîtizer	n of What Cour	ntry?
	ath w		10519 Abingdon					21163			nited S	
	er de Items ner n	Funeral	11. Marital Status 1 □ Never Married XXMarri	Armed F	cedent Ever in U orces? 2X No	J.S. 13,	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0- 14.	Race - Americ Black, White,	
36	should be filed within 72 hours after death with the Maryland of Mental Hygjene. marked other than "natural", or Items 23a or 28a-f show market event, the Medical Examiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1 ☐ Yes 2 No	Specify:		S	pecify: K	orean
21215-0036	2 hou atura cal E	ed	15. Decedent				dent's Usual Occupa			16b. Kind	of Business/In	dustry
215	thin 7 ie. ian "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)) (1-4or 5+)	life.	kind of work done o	during most of w)	orking			
2	d wit giene er th	Son C	, (,	4			Miņ	ister			Relig	ion
g	be filed stal Hygi od other event, t	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle	e, Maiden Su	ırname)	
<u> </u>	should be ind Mental marked o umatic eve	ည	Eunshik Park					Il	sun Lee	Park_		
Maryland	2 sho n and is ma		19a. Informant's Name/Relationsh	, , , , ,			ng Address (Street a					,
_	is 1 and 2 should of Health and Meritem 27 is marke other traumatic	15	Joshua K. Park	- Son	206	1051	9 Abingdo	n Way,	Woodstoc Date		ryland	
20			20a, Method of Disposition XX Burial 2 ☐ Cremation		State	cemetery, cre-	matory or other plac	, 00	nuary			•
altimore,	permit. Pages Department of Important: If i any injury or once.		4 □ Donation 5 □ Other (S _i 21. Signatura of Funeral Service I			adowrid	ge Mem. P 2. Name and Addres		8, 2008			aryland
Ba	perm Depa Impo any i		21. Signature of Fulleral Service	2.0.	M00053			G				al Home at
r			23a. Part1. Inter the disease, or	complications that	caused the dea						kriage	MD 21075 Approximate
	Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.				. ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		lepatoce (or as a conse		Carcinon	2				months
b	Examiner				Chronic	. ,	tus B					months
	7	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a conse		out D					MOTTETIS
8(cuted	Examiner	Cause (Disease or Injury that initiated events	c								
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to	(or as a conse	quence of):						
8760,	icate b physic s the b	dical		d		<u>·</u>						
9 X	ertific ding p	/Me	IF FEMALE:	230 If you o	utcome pf pregr	anov						
Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fe	tal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
o i	ires that the de signed by the be detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki		dodin o'E						
J.	that hed b	y P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
Records,	quires n sign uld be	d by							_ 1□	Yes 2□	No 3□ Prot	oably 4000nknown
ပ္သ	aw require s been si	Completed							24a. Was		24b. Were auto	opsy findings available
	The lav te has age 2	E O							- auto perl 1⊟ Yes	ormed?	prior to co death? 1 ∐ Yes	mpletion of cause of
Vital	ian: rtifica	BeC	25. Was case referred to medical					26. Place of D	eath (Check only			2010
	Physician: The Is this certificate ha ral director, page 2	일	examiner? 1 ☐ Yes ② ☐No	Hospital: 1 □	Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Othe	er: 4 🔀 Nursing	Home 5 Res	idence 6 [☐Other (Specia	(y)
Division or	ng fte		27. Manner of Death ↑ Satural 5 ☐ Pending	28a. Date (Mos	e of Injury nth, Day Year)	28b. Time o Injury	Worl	y at k?	28d. Describe	how injury o	occurred	
210	Attendi death. ctor: A y the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation				Yes 2 □ No				
\leq	or At ifter d Direct in by	Certification:	4 ☐ Homicide determi	and Zoe. Plac	ding, etc. (Spec	nome, tarm, sti sify)	eet, factory, office		City or To	(Street and I wn, State)	Number or Hura	al Route Number,
_	pital ours a neral filled		29a. Certifier XX Certifyin	g Physician: To th	e best of my kr	nowledge, deat	h occurred at the tin	ne date and pla	ice and due to the	Calleb(e) ar	nd manner as s	stated
	e Hos 24 he e Fur letely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examir	nation and/or in	vestigation, in my o	pinion, death oc	curred at the time	, date and pl	lace, and due t	o the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier		ve/		29c. License	e number		29d. Date s	signed (Month,	Day, Year)
)				chi	D	MD	D005	3150		Janus	ary 14.	2008
•	5		30. Name and address of person	who completed cau				<u> </u>		Janua	41 Y 14,	2000
_	<u> </u>		Shakunmala Gupta				d., Suite	110, C	olumbia,	Mary]	land 21	045
	Sta		31. Date filed (Month, Day, Year)	Q 2000	Registrar's Sigr	nature	Sanath 1			_		
	Registr	ar	JAN 1	8 2008	negistrar's Sign	85° A						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Pugo oretta Sonvary 11:47 M 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns Hopkins HOSDITA CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🂢 F 214-66-3994 Yrs. Director 55 Oct.11,1952 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene.
The filem 27 is marked other then "nature!, or items 23e or 28e-f show the traumatic event, the Medical Exemples mortal bannothing any or other traumatic event, the Medical Exemples mortal bannothing as 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits il Hygiene. other then "naturel", or Items 23e or 28e-f ehow vent, the Midical Exeminational be notified at MD Anne Arundel Glen Burnie Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Pinetop Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Bartender Restaurant 17. Father's Name (First Middle Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Woodrow Thomas Lancaster Lorretta Regine Manning ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Manuel Pugo /Husband 1009 Pinetop Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 19. 1 X Byrial 2 □ Cremation 3 □ Bomoval from State permit. Page: Department o Importent: If I eny njury or-4 □ ponation 5 □ Other (Specify Glen Haven Mem. Park 2008 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Sign 2nd Avenue SW Glen Burnie MD 21061 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypotensian disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Distress ute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WEED J Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit ymphoma VERY. Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Deetal death in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred s effer dea. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours e To the Funerel [filled Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated.

Division of Vital Records, P.O. Box 68760. ş

> State Registrar

29b. Signature and title of certifier

Bisrat Abraham 31. Date filed (Month, Day, Year)

8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Johns Hopkins Hospital

32. Registrar's Signature

DHMH 17 Rev 1/2001

medical doctor

RES - 000

29d. Date signed (Month, Day, Year)

January 14,

600 North Wolfe street, Baltimore, Moryland 2/287

			1 - For State Registrar	State of M	larylan		artment <i>rtificate</i>			and Me	-	giene Rag. No.	MA	8	00959
	Physic /Medi		1. Decedent's Name (First, Middle, a			RA	ENS	KI			Date of De. Month	Day	1 20	rear	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, g	d Ave.				alti	more	City			County of		N/A
	Funeral Director		5. Social Security Number 218-07-5899 Usual Residence of Decedent	.Sex 7. A ¥□ M 2□ F 86		ast birthday) Yrs.	If Under 1 Months	Days	If Under a	Min.	Date of Bin (Month, Da Jan	y, Year) 30 , 19	921	Count Mar	ace (State or Foreign ry) :yland
	Maryland I-f show	tor	10a. State 10b. County Maryland N/A		10c. City	, Town or Lo	cation			Ва	ltimo	re C:	10d. Inside City Limits City 1 XYes 2 No		
	with the	i Direc	10e. Street and Number 6730 Graceland	ATT.			10f. Zip (Code 212	24			_	zen of Wr ited		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene Item 27 is marked other then "naturel", or itams 23a or 28e-f show other treumetic event, the Madical Examinar must be rodified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? No		Was Deceder f Yes, specif	ent of His fy Cubar		gin? (Specit , Puerto Ric	y Yes or No can, etc.)		14. Race		n Indian, tc.
21215-0	filed within 72 ho Hyglene. other then "natur ent, the Medical	Completed	15. Decedent's (Specify only highest (Specify only highest (Dementary/Secondary (0-12) 12 Years	Education grade completed) College (1-4or	5+)	16a. Deced (Give life.	lent's Usual kind of work DO NOT use Welc	done di retired)	tion uring most	of working		16b. Kii	nd of Busi		ustry
Maryland 2	2 should be filed withir and Mental Hyglene. Is marked other then eumetic event, the M	To Be C	17. Father's Name (First, Middle, La	•	Rajews	ski	,,,,,				First, Middle, Kracz		Sumame,		
	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship Mr. Robert T.		Son)						Route Number Bel A:	-		-	^{Code)} 21014
Baltimore,	0 0		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		, ce	ace of Dispo emetery, crem exed H	natory or oth	ner place		Dat			cation - C unda]		wn, State Maryland
Balti	permit, Pag Department importent: i any injury o once.		21. Signature of Juneral Service Lice	ensee	9	22	Mamaaad	Address Ruck	s of Facility Fune	ral H	ome of dalk,	f Dui	ndal	i, Ir	
1	Pnysician	V. 11	23a. Part1. Enter the disease, o co shock, or heart allure. List on Immediate Cause (Final disease or condition	mplications that cause by one cause on each	_								· · · · · ·		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	b. Due to (or as	s a consequ	RILL	ATTON	J							
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. End Whomping Cause (Disease or injury that initiated events resulting in death) Last	c. HYPESTENSION Due to (or as a consequence of): d								· · · · · · · · · · · · · · · · · · ·			
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗍 Fetal	death 3	Ectopic pred						23d. Date of delivery Month Day Year		
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death		-	nderlying cau	use give	n in Part I.		23e. Did to		P		e cause of death?
Vital Records,	The law ate has b page 2 sl	Completed	CHRONIC RE	VAL INS	UFFI	CIEN	c4	<u>-</u>		_ '			pri	or to com ath?	sy findings available pletion of cause of
Vita	ician: certific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	201	ER/Outpatien	t 3 DOA	Othe	~		Check only o	ne)		10	
ion of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Da	ury	28b. Time of Injury		c. Injury Work	4 LI Nui	286	5 / Resid				
Division	or A	Certification:	3 ☐ Suicide 6 ☐ Could not determine	A 289. Place of II	jury - At hor tc. (Specify	me, farm, stre	eet, factory,	office		281	Location (S City or Tox	Street and vn, State)	d Number	or Rural	Route Number,
	To the Hospitei within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier 1 A Certifying I (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examinati	vledge, death on and/or inv	occurred at restigation, in	t the time n my opi	e, date and inion, deat	d place, and h occurred	d due to the at the time,	cause(s) date and	and manr place, an	er as sta d due to	ited. the cause(s)
	To the within 2. To the to complet	Σ	29b. Signature and title of certifier	16.	/	110		License					e signed (
	nXI	-	30. Name and address of person wh	o completed cause of	death (Item		Print)		203			ンケン	UMR	7 10	2008 144/15HI
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	CACL rar's Signati	ure 4	LTIM	ore	. Mī	212	224 (JEA	NIF	ERH	AMASHI)

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of	Marylan		artment rtificate			and M		giene Reg. No.		8	009	61
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De				3. Time of D	eath
ı	Physici /Medi		Mildred L. Spears	3							Month	Day			0635	A M
je.	Examir		4a. Facility Name (If not institution, given	e street and num	nber)		4b. City, To	own, or l	Location o				County of D			
		4.	FRANKLIN SQUAR						- da						012	
	Funeral			Sex 1□M 2 ∏ F	7. Age (In yrs.		If Under 1 Months	Year Days	If Under : Hours	Min.	Date of Bir (Month, Da	y, Year)	9.	Birthpla Counti	ace (State or F	oreign
	Director		215-28-5501 Usual Residence of Decedent		75	Yrs.					06-23-	1932		aryl		
	and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City	Limits
	Maryl f sho ied a	5	26 1 1 77 6												1 □ Yes 2	
	h the Marylan r 28a-f show notified at	Director	Maryland Harf 10e. Street and Number	ora		Abingd	On 10f. Zip C	ode				10g. Citi	zen of What	t Count	v?	
	eath with ns 23a or must be		3805 Memory Lane	Apt F				009				-	J.S.A.		•	
	death ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - A			
9	ours after c ral", or iter Examiner		1 ☐ Never Married 2 ☐ Married	Armed For	2 X No			_		i, Puerto F	Rican, etc.)		Black, W	Vhite, e	tc.	
03	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	ğ	3 Nidowed 4 Divorced	If Yes, Give Year or Da	e ites:		1 ☐ Yes 2	A No	Specify:				Specify:	Whi	te	
5-0	in 72 hours n "natural", ledical Exa	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual (kind of work DO NOT use	Occupa done du	tion uring most	t of workin	a	16b. Ki	nd of Busine	ess/Indu	ıstry	
21		ם	Elementary/Secondary (0-12)	College (1-	-4or 5+)			retired)	3							
2	e filed wal Hygie other tivent, the		8			Home	maker		40. 14-11	-11	/ Park A 47 - 2 - 12		Home			
Maryland 21215-0036	ges 1 and 2 should be filed within the filead within the Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Meren than	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	, Maiden	Surname)			
Ĕ	2 should be f and Mental is marked of raumatic eve	은	Lee Miskimon	(T D1)		1405 14.35					oinson					
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e,	les 1 and 2 of Health a of tem 27 is or other tra		Frank Spears, Jr.	•	20b. F	_1					lon, MD		cation - City	or Tou	ın State	
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ij	mit. Papartme spartme portant y Injury	1	4 ☐ Donation 5 ☐ Other (Special Services Lice		Oak	klawn (Cemeter 2. Name and .				3-2008			100	Marylar	
Ba	permit. Pages Department of Important: If is any Injury or once.		1666	Olg		Ir	nc. 610	O W.	Mac.	Scn: Phail	imunek L Rd Be	el Ai	ral H	ome 21	of Bel 014	Air
			23a. Fart1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the deatl ach line.	h. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Betwe Onset and De	en
	Physician		Immediate Cause (Final disease or condition	a Lu	na c	anc	25							-1	Onset and De	auı
7	/Medical Examiner		resulting in death)	Due to (d	or as consequ	uence of):		1								
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687	icate phys s the	dic		▲d										+		
×	death certifica attending ph	Physician/Med	IF FEMALE:	23c. If yes, outo	ome of pregna	ancv							204 D-44	at a Division		
Вох	ath atter	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	rth 2 ☐ Feta ant at time of d	ideath 3□	Ectopic preg					11.2	23d. Date of Month		y Day Yea	ar
Ö	0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkno		eau o	Jones (spec	y/								
٦.	that ed by deta	h h	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the ur	nderlying cau	se giver	n in Part I.		23e. Did to	obacco u	se contribut	e to the	cause of dea	ath?
Vital Records,	requires that the een signed by the	d by									1 🗆 '	Yes 2[≥ N₀ 3[] Proba	bly 4 ∐Uni	known
Ö	S □ S	Completed									24a. Was		Oth Was		sy findings av	-11-1-1-
Re	The law ate has b	du									autor		prior deat	to com	pletion of cau	se of
a	n: T fficate or, pa		25. Was case referred to medical								1□ Yes	2⊡No	1 🗆 🗎	Yes 2	!□ No	
Ē	slcia cert irect) Be	examiner?	Hospital:	patient 2 🗆	ED/Outpotion	* 2000	Other			(Check only o					
Division or	Attending Physician: The lar death. r death. sctor: After this certificate has by the funeral director, page 2	5	27. Manner of Death	28a. Date o	f Injury	28b. Time of		Injury Work?	4 🗆 1101		ne 5 Residente R			Specify)		
on	th. th. : Afte	흕	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		n, Day Year)	Injury	М		? es 2⊡1			,,	,			
/isi	Atter r dea ector by the	lfica	3 Suicide 6 Could not b	≥8e. Flace (of injury - At ho	ome, farm, str	eet, factory, o	office		2	8f. Location (Street an	d Number o	r Rural	Route Numbe	er,
Ö	al or s after Il Direction to	Certification:	4 Horriicide assertimes	buildin	g, etc. (Specif)	y)					City or Tov	vn, State)			
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical (29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the I miner: On the ba and mann	sis of examina	wledge, death	occurred at vestigation, ir	the time	e, date and inion, dea	d place, a	nd due to the ed at the time,	cause(s) date and	and manne I place, and	er as sta due to	ted. the cause(s)	
	To th within Го th	Me	29b. Signature and title of certifier				29c. L	icense	number			29d. Dat	te signed (M	lonth, D	ay, Year)	
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ń	V	-	30. Name and address of person who	1			Print)	_		-	/					
1	•		DR Binh nouver		FRANKL			Ita	SOLTA	46	OR BE	ALTO	mo)	21237	7
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture A	C.	., .	-6-11							
	Registr	ar	JAN 1 8 200	S CON	See Ast	1 Para	puge III									

DHMH 17 Rev 1/2001

mildred

Spears

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 16 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOS PITAL timo If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days 10 M 2□ F Director March 31,142 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examlner must be notified at 1 Nes 2 No Md Director IMOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 3 No δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Va ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) twood Esther Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 1-08 1-2 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 27 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or candition resulting in death) MENTIA CN3 STAGE **Physician** /Medical Due to (or as a consequence of): SCUD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seconcletely filled in by the funeral director, page 2 seconcletely filled in by the funeral director, page 2 seconcletely filled in by the funeral director. autopsy death? 1 ☐ Yes performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) **2**☑ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Priot)

Sharam 8813 Wall Tram Woods Road.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 50A M a008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist altimore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours 1 M 2 7 216-34-6154 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 1 Yes 2 No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? *ରା*ଧାର Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ 100

If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10+ aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be arence staten baran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once, Thomas/Granddayhor 320 Ilchester Ave Baltimore, MU 21218 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation M+Zion Cemotery 11/17/2008 | Baltimore, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Ad less of Facility Vaynn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York And Baltimore, MID 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC QUAMOUS CELL CARLINOMA OF KIM YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and I-transit Due to (or as a consequence of): Box 68760, attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy 5 □ Other (specify) ___ 1 ☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ADENO CARCINOMA OF RECTUM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy pertormed? Yes 220No certificate Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Jospital C.
4 hours after dec.
---neral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To unc.
within 24 hours and.
To the Funeral Direct 4 Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 JANUARY 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST, SWITE 209 BALTIMME, MO 21204 DANIEUE DEBERMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** Month Smock 7:05 AM 2008 /Medical JANUARY 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTEROMERY VILLAGE NURSING CENTER MONTGOMERY GAITHERSBURG If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) **02/07/1917** 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MA Country) 90 Days 1 □ M 2KXF 034-07-3471 Vrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD Director Montgomery 1 □Yes 2/XNo Montgomery Village 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 19301 Watkins Mill Rd. 20886-USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. The Wall of the Wall Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify <u>م</u> Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Higher Education College (1-4or 5+ Elementary/Secondary (0-12) **English Professor** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Jorgensen Maude Ellison 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Jorgensen / Nephew 16 Carolina Main St., Carolina, RI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 16 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²² Name and Address of Facility Rapp Funeral & Cremation Services 1400382 Style D Holermann 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner Hypernatremia burial-trar Due to (or as a consequence of): 68760, signed by the attending physician to be detached for use as the buria Physician/Medical Hypertension IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) ₽ .O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Spinal Stenosis No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2**X** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: AXNursing Home 5 | Residence 6 | Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) ant January 17, 2008 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D. 19529 Doctors Dr., Germantown, MD 20874

Registrar

State

31. Date filed (Month, Day, Year)

JAN 18

705 AM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Rebecca Slaughter	1. For State	tate of Maryla	•	artment of rtificate of		Menta	• -	Reg. No. 20	08 0096
Physician/							2. Date of De	ath	3. Time of Death
Medical Examine		0					Month January	8, 2008 Year	0930 hrs
	4a. Facility Name (if not instituti Silver Knob Road	on, give street and nu	imber)	4	b. City, Town, or Lo Oakland	ocation of E		4c. County of D Garrett	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	4Hrs. 8. Date of E	Birth(MM/DD/YYYY) 9	Birthplace (State or preigrWeSt Virginia
Director	232-80-2213	1 M 2 X F		57 Yrs.	MOII(IIS Days	Hours	Sept	25, 1950	Country)
any	Usual Residence of Decedent 10a. State 10b. County	,	10c, City	, Town or Location	on	-			10d. Inside City Limits
*	West Virginia Mon	ongalia		Morga	ntown				1 Yes 2 X No
the Maryland a or 28a-f sh Liffed at once	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
vith the Maryland s 23a or 28a-f show s e notified at once. ral Director	223 Hagan St	reet			2650	05		USA	A
r death with or items 23 must be no	11. Marital Status	A a d =	cedent Ever in U		Decedent of Hispa s, specify Cuban,		? (Specify Yes or Nuerto Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
er deat		Married Armed F 1 Yes Vorced If Yes, Give Yes	2X No		Yes 2 X No				√hite
urs afte tural" amine	15 Decedent's Education (Co	or Dates:		16a. Decedent	's Usual Occupation	n (Give kin	d of work done	16b. Kind of Busin	
S 72 hor n "na al Ex	Elementary/Secondary (0-12) College (1-4 or 5+)		st of working life. I		e retired)		. 1
5-0036 filed within 72 hour Hygiene. 1 other than "natt the Medical Exa			<u>. </u>	Regi	stered N			Hospi	ıtal
15-(filed v filed v ti the	17. Father's Name (First, Middle Basil Slaug				18		Name (First, Middle tha Matus	, Maiden Surname)	
2121: ould be fil d Mental I s marked lic event,	19a. Informant's Name/Relation			19b. Mailing	Address (Street			umber, City or Town, S	State, Zip Code)
MD d 2 sho lth and th and someti	Andrew D. S	laughter,	Son	905 As	hton Plac	ce Mo	rgantown,	WV 26508	
re, leg land freal	20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal fr		Place of Disposi crematory or oth	tion (Name of ceme er place)	etery,	Date	20c. Location - Ci	ty or Town, State
imo Page nent o ant: J	4 Donation 5 Other 3		Met		atory Ind		01/15/08		ce, Maryland
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service	W.		22. ك	remation	Soci	ety Of Ma	ryland, Ir	nc. Cyland 21228
Physician	Thomas Grego 23a. Part I. Enter the disease, of	r U	aused the death	Do not enter th	99 Frede:	uch as card	ROAD BALT	IMOre, Mai	Approximate Interval
/Medical	failure. List only one caus	e on each line.					. ,		Between Onset and Death
aminer	Immediate Cause (Final diseas or condition resulting in death)		consequence of		011				
۔	Sequentially list conditions,	b		- 6\					
nine	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated		consequence of	or):					
led Insit	events resulting in death) Last	Due to (or as a	consequence of	of):					
execui an and al - tra	UNPENDED	d AMENDED							
	IF FEMALE:		outcome of preg	gnancy				23d. Date of de	livery
x 68760 h certificate b tending physic use as the bu	23b. Was decedent pregnant in past 12 months?	I - Eive	oirth nant at time of de		al death 3	Ectopic p	regnancy	Month	Day Year
Box e death c the atten ed for us hysic	1 Yes 2 No 9 U			eath 5 Oth	er (Specify)				
P.O. Box 68760 ss that the death certificate I ganed by the attending physic detached for use as the brown I by Physician/Me	Part II. Other significant cond	itions contributing t	o death but not i	resulting in the u	nderlying cause gi	ven in Part			te to the cause of death?
of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed uneral director, page 2 should be deta in: To Be Completed by							- 1/4		Probably 4 Unknown
(ecords, let law requires are has been signage 2 should be ompleted	<u> </u>		_					opsy pric	re autopsy findings available or to completion of cause of
Rec The la ficate h page 2								formed? dea s 2 No 1 v	Yes 2 No
cian: certifi ector,	25. Was case referred to medic examiner?	Wessitel:		1	r)ther:	heck only one)	1	
of Vital Records, ling Physician: The law require After this certificate has been sifuneral director, page 2 should bon: To Be Completed	1 Yes 2 No 27. Manner of Death	28a Date	Inpatient 2	ER/Outpatient 28b. Time of Ir		-	Nursing Home 5 28d. Describ	Residence 6 🗸	
Division o ital or Attending Lrs after death. Ral Director: After led in by the fune ertification:	1 Natural 5 Per	nding FOUNE	Day,Year)	FOUND:		es 2 🗸 N	Subject de	ank anti-freeze	
Division ratendin rs after death. al Director: A led in by the fulled in		uld not be Jan 7, 2		1400 hrs nome, farm, stree	t, factory, office bu	ilding, etc.			or Rural Route Number, City
Division Spital or Attendours after death neral Directorath filled in by the Certificati			Woods				Silver Knob	, State) Road , Oakland , I	MD
S II E >	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the be	st of my knowled	dge, death occur	red at the time, dat	e and place	e, and due to the ca	ause(s) and manner as te and place, and due	s stated.
To the He within 24 To the Fo complete!	29b. Signature and title of certif	and manner s	stated.	- Indict investigati	29c. License		at the time, de		(Month, Day, Year)
		PUI.			O.C.N			January 9, 2	
	30. Name and address of person	n who completed cau	se of death (Iter	n 23a)					
- (o	David Fowler M.D.	Chief Medical E			reet, Baltimore	e, MD 21	201		
	31. Date filed (Month, Day, Year	2008 32.R	egistrar's Signat	ure	A P				
Registra	JAN 1	2000 3	Bar Alest A	So Allenda	Roll				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00966 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 16, 2008 ear **Physician** Orville W. Shinnick 2:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Baltimore Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 7, 1920 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** XX M 2□ F Maryland 87 214-18-6854 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Harford 1 ☐ Yes XX No Bel Air Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 510 Mast Street 21014 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes YX No If Yes, Give Year or Dates: 1 Never Married XX Married 1□Yes 2⊞No Baltimore, Maryland 21215-0036 Specify. Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kunkle Piano Elementary/Secondary (0-12) College (1-4or 5+) Sales permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important; If Item 27 is marked other tha any injury or other traumatic event, the 1 once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ormsby Shinnick Mable B. Schave 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest

EVANS FUNERAL CHAPEL

AND CREMATION-Belair

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Anna Mary Shinnick-spouse

4 Donation 5 Dother (Specify)

21. Signature of Funeral Service Licensee

1 ☐ Burial XX Cremation 3 ☐ Removal from State

20a. Method of Disposition

447

31. Date filed (Month, Day, Year)

(LULY)

32. Registrar's Signature

nding physician and use as the burial-tran

Division or Vital Records, P.O. Box 68760,

shock, or heart failure. List only			1 -	· · · · · · · · · · · · · · · · · ·		Interval Between Onset and Death
Immediate Cause (Final disease or condition	a. Callina	- ANYP	st			Min-tes
		stores to	Juse			MINITES
sequentially list conditions, if any, reading to inmirediate cause. Enter Underlying Cause (Disease or injury that initiated events	A	ation Du	earmin at			Sen gun
resulting in death) Last						Sev-dons
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live birth 2 ☐ Feta	al death 3 □Ectopie			23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlyin	g cause given in Part I.			
				24a. Was an autopsy performed? 1□ Yes ১ No	prior to death?	utopsy findings available completion of cause of 2 No
25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing F	forme 5 ☐ Residence	3 □Other (Spe	cify)
Z L Accident		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At n	ome, farm, street, fact fy)	tory, office			ural Route Number,
29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurration and/or investigat	red at the time, date and plac- tion, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as i place, and due	s stated. e to the cause(s)
29b. Signature and little of certifier (M WY		29c. License number	29d. Dat	e signed (Mont	th, Day, Year)
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any reading to final class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury and included in the past of the cause of th	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, reading to final disease or consequence of): Sequentially list conditions, it any, reading to final disease cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I. Due to (or as a consequence of): Cause (Disease or injury and time of death or injury (Disease or injury and time of death or injury (Month, Day Year) Due to (or as a consequence of): Due to (or as a conse	Due to (or as a consequence of): Due to (or as	Sequentially list conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions, flarity, reading to marie land conditions contributing to death but not resulting in the underlying cause given in Part I. If FEMALE: 23d. Date of del months? 1 1 23e. Did tobacco use contribute to the land conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the land conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the land conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the land conditions contribut

MO

ORIGINAL

510 Mast Street-Bel Air, Maryland 21014

22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES

20c. Location - City or Town, State

Forest Hill, Maryland

3 Newport Drive

21043

Forest Hill, Maryland

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar	State of Ma		epartment Certificate			, ,	ene 1. No.2 A A A	00067
Ų		·	Decedent's Name (First, Middle, Last	et)			0, 500		. Date of Death	- 2000	3. Time of Death
	Physicia /Medic			Charl	es W.	Snyder			Month January	Day Year 7 15,2008	11:50A M
	Examin	er	4a. Facility Name (If not institution, give	,		4b. City, To		tion of Death		4c. County of Dea	th
		8	3403 Liberty Pa. 5. Social Security Number 6. S	-4	(In yrs. last birtho	day) If Under 1	Dund:		. Date of Birth		more Co.
Most	Funeral Director		· ·	X M 2□F	79 Yr	Months [urs Min.	(Month, Day,) July 5, 1	(ear) 8. Bl. 1928 Mar	thplace (State or Foreign ountry) cyland
	/land ow at		10a. State 10b. County	·	10c. City, Town o	r Location					10d. Inside City Limits
	a-f sh ified	ctor	Maryland Balt:	imore				Dundalk	:		1 ☐ Yes 2K∑No
	ith the	Director	10e. Street and Number			10f. Zip C			109	g. Citizen of What Co	•
	ath w	ral	3403 Liberty Par				1222			United St	
30	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or Items 23a or 28a-f show dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 15☐ Yes 2☐ N If Yes, Give	0	13. Was Deceder If Yes, specify 1 ☐ Yes 24			fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
-0030	hour tural		15. Decedent's Ed	Year or Dates:	WWII 16a. D	ecedent's Usual (Occupation		10	6b. Kind of Business	
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7	d with giene er tha sr the I	Completed	12 Years	College (1-401 3	''	Supervi	son			Steel In	dustry
9	be filed ital Hygi id other event, t	Be (17. Father's Name (First, Middle, Last)							aiden Surname)	
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2	ロヤンコ	l lx	19a. Informant's Name/Relationship (1 Scott W. Snyder	(Son)	40) Torner	Road		Maryla		
paltimore	permit, Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 3 ☐ Other (Specify		cemetery,	isposition (Name crematory or oth Lawn Cem	er place)	1/19/		oc. Location - City or Baltimore	Town, State , Maryland
סמוני	permit. Departr Importa any injt		21. Signature of Funeral Service Licen	\$800 A			luck Fr	uneral E		Dundalk, Maryland	
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	/Medical Examiner		resulting in death)	Due to (or as	donsequence of	0	152 ×	6			
	Latimici	<u>.</u>	Sequentially list conditions,	b. Due to for as	consequence of)		501				
	nsit 7	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence or,						
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	± ~ ~	Med	IF FEMALE:	-	-						
O. DOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Ver the Fundral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Yes 2 No 19 Unknown 1 Yes 3 Yes 4 Yespanat at time of death 1 Yespanat at time of							23d. Date of de Month	livery Day Year
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necolus,	he law red e has bee age 2 shou	Completed							24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
2	ian: rtifical	Be C	25. Was case referred to medical				26. F	Place of Death (ZNo 1 ☐ Yes	s 2 No
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222	after d after d I Direc d in by	Certification:	4 Homicide determined	28e. Place of inju building, etc	ry - At home, farm . <i>(Sp</i> ec <i>ify)</i>	, street, factory, o	office	28	f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)	ysician: To the best on the basis of and manner sta	examination and/	leath occurred at or investigation, in	the time, da n my opinion	ite and place, an	d due to the cau l at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the vithin To the comple	Me	29b. Signature and tiple of certifier	// //	11	29c. l	icense num	ber	29	d. Date signed (Mon	th, Day, Year)
			I A YV	allo	W/	3	D15	408		01-15	-08
	10+1		30. Name and address of person who	5t SUIT	e CR	ALTO 1	ND	212			
SS .	Sta Registr	- 1	31. Date filed (Month, Day, Year) JAN 18	32. Régistra	r's Signature	Joseph					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, Pt I, II, 25, 27, 28a-f, per me, 2878, 04/14/08dhb Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Norman Daniel Swoboda C4: OL4 M 01. 16. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St Agnes Hospital 5. Social Security Number 6. Sex BALtimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Nov 28, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Country) MD Days Months 1 ☐ M 2 ☐ F 218-22-5787 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 Newfield Road 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White by Specify: 3 Widowed 4 Divorced Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin F. Swoboda Catherine Anna Mattison ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Swoboda (Wife) 1114 Newfield Road Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 1/19/2008 Sykesville, MD 21. Signature of Funeral Service Licenses Haight Funeral Home & Chapel (Box 195) Sykesville, MD 21784 Brian (Hugh M00164 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsus disease or condition resulting in death) CERTIFICATION APPROVED BY MEDICAL EXAMINER /Medical Due to (as a consequence of): **Examiner** Pheumous Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vonknown STructile Dr Imm acy Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ √ No complicating Hip Fracture 24a. Was an autopsy performed?

1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 YES Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Subject tripped over cable 28c. Injury at Work? Certification: Tylvatural 5 ☐ Pending investigation 10:02 a 11/07/2007 1X Yes 2 □ No 2 Accident wire and fell. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9800 Emory Rd., Ft. George G. Meade, MD 4 Homicide determined Military Reservation To the Hospital 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01.16.2008 P22256 FETHI BENRADUANE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caton AV BALTIMORE, mo 21229 1851- Agny Hospital FETHI BENRADULANE 32 Registrar's Signature 31. Date filed (Month Day Year) 2000 State

DHMH 17 Rev 1/2001

Registrar

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8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 00969 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Gloria Stewart 1015 A M January 14,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3811 Baker School House Road Freeland Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Days Hours **Director** 215-66-3259 Sept. 8,1957 Marvland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland 1 ☐ Yes 2 ☑ No Director Baltimore Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3811 Baker School House Road 21053 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 Pipivorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Becton Dickinson nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Scientist and Company 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked o Sarah Oliver Hunter Mundy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kirk Denisuk (Fiance) 3811 Baker School House Road Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Towson, Maryland 1/19/2008 Hilltop Service Corp 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?

1 ★ Yes 2 □ No funeral director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Suic.de Certification: 28c. Injury at Work? 1 Natural 5 Pending 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 📉 No investigation By Hanging 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 281. Location (Street and Number or Rural Route Number of City or Town, State) 381189 Km School Frae Land, MD 21053 after Dire tome 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

To the Hospital or Attending Physician: within 24

> State Registrar

29b. Signature and

PHILIP MILITELLO 31. Date filed (Month, Day, Year)

O. Name and address of person who completed cause of death (Item 28a) (Type, Print)

MD 32 Registrar's Signature A Sugar

6 Trimble Hill CT. Lytherville, MD 21093

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

State

10724

31. Date filed (Month, Day, Year)

Cittle

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 12:27 PM Saierski Wank Januar 200 K /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayriew Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year, Jan 10, 1931 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ₩ 2 □ F 212-28-0477 77 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notified ¥ Yes 2 No Director Md. n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 629 South Kenwood Avenue 21224 U.S.A. items 23a Examiner must Pages 1 and 2 should be filed within 72 hours after death vernent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐X/es 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or Specify: White 1 ☐ Yes 2 🗷 No þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) s and Mental Hygiene. College (1-4or 5+) Telephone Cable Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Saierski, Rose Ruffo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other trau Joan Saierski (wife) S. Kenwood Ave. Baltimore, Md.21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus Jan 17,2008Baltimore, Maryland 4 Donation 5 Dother (Specify) 22 Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Juneral Service Licenses leo 1201 Dundalk Ave. Baltimore, Md. 23a art1. Enter the disea shock, or heart failur. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Immediate Cause (Final **Physician** Sersis

Due to (or as a consequence of): 4 days disease or condition resulting in death) /Medical Examiner Preumonia week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed Yes 2 After this certificate 1□ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Many er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Avenue Baltimore EasterN 21224 MD Hohleigh M.D

Registrar

State

31. Date filed (Month, Day, Year)

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STATE OF

32, Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Philip Transparent /Medical 2008 January 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal 1 Ne Johns Hopkins 5. Social Security Number 6. Sex If Under 24 Hrs. Hours Min. If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2□ F 215-18-9835 Director 84 Yrs February 11,1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director Maryland N/A 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 1013 Fawn Street 21202 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 MyYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 10 years Carpenter Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rocco Transparenti Incarnata Maletesta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a tem 27 is Santina Transparenti wife 1013 Fawn Street, Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 19, 2008 Dundalk, MD. 21 Signature of Juneral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Pair1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEGUN ADOXIC 11,702 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Thromboemballe 2 days Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pt for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 ☐ Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy perform certificate 2 N No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 C Zwyman, Medical Doctor January 16, 2008

State Registrar 600 North Wolfe Street Baltimore Maryland 21277

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timas

31. Date filed (Month, Day, Year)

JAN

Hopkins Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16a per fb. 26 per doc 8875 1-18-08 vt.

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 1 4:30p Thompson /Medical Yvonne 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>E.</u> Baltimore Oliver Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 ₩ F Months Yrs. Director 219-52-6759 61 8-25-1946 MD Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 28a-f show Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 1772 Homestead Street 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etc. Black 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: þ Specify: Specify. X□ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Nutritionist Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Ň/A 12th grade Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel R. Francis Evelyn Desmond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Lee Thompson-Son 2303 Velvet Ridge Drive Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-2008 Randallstown, MD King Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 21202 1101 E. North Avenue Balto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carcinoma Metastatic 21/2 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) P.0. the a 9 Unknown by. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 2 XNo 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? certificate Division or Vital 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 3 Nursing Home ပ hours after death.
uneral Director: After this of filled in by the funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred home Certification: the Hospital or Attending 1 Natural
2 ☐ Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jan 17 2008

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type, Print)

560 Loch Raven Blud 32. Registrar's Signatur

State Registrar DHMH 17 Rev 1/2001

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To the

29b. Signature and title of certifier

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

29c. License number

Road #301

Pages 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** Division or Vital Records, P.O. Box 68760 after death. To the Hospital o within 24 hours aft To the Funeral Di

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death with the

10 State Registrar

31. Date filed (Month, Day, Year)

Ronald

29b. Signature and title of certifier

Jeffreys, 32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8832 Walther Borleund, Parkville Maryland 21234 medis

29c. License number

52365

29d. Date signed (Month, Day, Year)

January 16, 2008

amend tatems warvalled / Bernamon of Treating and Mental Hygiene 1- State amend item 23a-b, Pt II, 27, 28a-f per M. 9877 3/20/08 and Registrar Amend Items 28bdef, 27 per me, 8877 3/20/08 and 28a 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 14:52 PM CHRISTOPHER 13 JANUARY MELSH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BATVIEW MEDICAL CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 4, 1962 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 215-84-0142 1 M 2 □ F 45 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 TYes 2 No Director Elkridge Maryland Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 21075 5802 Bonnie View Lane USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite Lry or other traumatic event, the Medical Examines 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Matthew F. Welsh Dorothy Frank ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Phipps, Mother 5802 Bonnie View Lane Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Metro Crematory Inc. 01/16/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Consecution Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Head Injuries with Complications Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SUBDURAL HEMATOMA to DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner he law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician a Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown Atter this certificate has Leen signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by Hepatitis C Infection, Drug Use 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? Yes 2☑No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28 Output Pound: Day Year) 28d. Describe how injury occurred

White the test of t 27. Manner of Death After t 28c. Injury at Work? Hospital or Attending 1 Natural DECEMBER 27 2007 07:42 AM 1 ☐ Yes 2 No death. investigation 24 hours after death Funeral Director: 6XXCould not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) **Found:**• STREET Parking Lot 28f. Location (Street and Number or Rural Route Number, OFCITAL State) 97
NORTHPOINT BOULEVARD, BALTIMORE, MD filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 0 RES-000 JANUARY 13 M.D. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI-MEI LIN 4940 EASTERN AVENUE BALTIMORE M.D. HD 21224 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 18 Registrar

			1- For State of Maryland / Department of Heal Certificate of Dea		6	1000	00977
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9800	4 within 72 hours after death with the Maryland liene. r than "natural", or liems 23a or 28a-1 show the Medical Examiner must be notified ut	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Me 1 Yes, Give Year or Dates: Armed Forces? 1 Yes, Specify Cuban, Me 1 Yes, Specify Cuban, Me 1 Yes, Specify Cuban, Me 1 Yes, Specify Cuban, Me 1 Yes, Specify Cuban, Me	exican, Puerto Rici	an, etc.)	Black, White	lack
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Maryland	s 1 and 2 should b f Health and Ment item 27 is marked other treumatic	٦ م	19a. Informant's Name/Relationship (Type, Print Caregiver) 19b. Mailing Address (Street and No.	lumber or Rural Ro	oute Number, City o	or Town, State, Z	CIACC (ip Code)
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P.O. Box	death cer e attendir od for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐			23d. Date of deliv Month	very Day Year
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Vital	Physician: The lav r this certificate has ral director, page 2	Be	examiner/	Place of Death Co		1	2 No
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	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edlcal (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and , death occurred a	due to the cause(s)	and manner as I place, and due	stated. to the cause(s)
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S.	Sta Registr		31. Date filed (Month, Day, Year) AN 1 8 2008	1 1 1 4 1	77.70.0		2

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	_		Decedent's Name (First, Middle	e, Last)			inoatt	01 2	Cairi		2. Date of Dea	Reg. No.		3. Time of Death
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			522 Thomas Run	Road			Be.	L Ai	r				Harfor	rd
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2X7 F	7. Age (In yrs. I		If Under Months	1 Year Days	if Under a	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Year)	9. Bi	rthplace (State or Foreign country)
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	23a c	Funeral Director	522 Thomas Run	Road				210	15			1	USA	
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21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow Ita Madical Examinar musi ke notilified at	ed b	15. Deceden	Year or	Dates:	16a Decer	dent's Usual	I Occupa	ition			16h Kin	of Busines:	hite
15	n ne	Completed	(Specify only higher	t grade completed		(Give	kind of world	k done d e retired)	u <i>ri</i> ng most	t of workii	ng	TOD. KIIK	1 Of Business	arii dustry
212	d with	mo;	Elementary/Secondary (0-12)	College	(1-4or 5+)		Homer	nake:	r			0	wn Hon	ne
p	al Hy fotha	BeC	17. Father's Name (First, Middle,	Last)							(First, Middle,		umame)	
<u> </u>	Menti Menti Prked	2	Andrew Morgan	Jackson					Lill	ie M	ay Mear	S		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show say injury or other traumatic event, the Misclical Examinators as to notified at ODGs.		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a	n <i>d Numbe</i>	r or Rura	Route Numbe	r, City or	Town, State,	Zip Code)
	l and tealth im 27 im 27 ihsr tu		Sandra L. Gree	ne / Daug					un Ro		Bel Air			
ŏ	in to the state of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	lace of Dispo emetery, crer	natory or oti	her place	· 1				•	r Town, State
Baltimore,	it. Pa		4 □ Donation 5 □ Other (S		Hil	lltop :			-			Tow	son, M	aryland
Ba	Depa Impo eny ir		1 M	11/1/		Mo	. Name and	s Fw	neral	Hom	e, P.A.		- 010	
			23a. Part1. Enter the disease, or	complications that	caused the death						Abingo r respiratory ar		MD 210	Approximate
	Pnysician :		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		. 1	10	/	-				Interval Between nset and Death
a	/Medical		disease or condition resulting in death)	aDue to	(or as a consequ	rence of):	107	en	ural	3°C				To Hours
	Examiner					,								
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	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, or	utcome of pregnar	ncy						22	ld. Date of de	aliven/
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ğ	w require been sig should b	pe	Intra HSC	minal	Mes	/Cel	ione				1 🗆 Y	es 2,80	No 3□F	Probably 4 Unknown
Records,	e law re has be se 2 sho	Completed by									24a. Was		24b. Were a	utopsy findings available completion of cause of
<u> </u>	ysician: The is certificate hadirector, page	E C									perfo	med?	death? 1 ☐ Ye	
/ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?							of Death	Check only of	ne)		
Division of Vital	Attending Physician: r death. ector: After this certifice by the funeral director.	2	1 Yes 2 No			ER/Outpatien			4 LINUI		ne 5 Resid			ecify)
ב	ding Ph	io	27. Manner of Death 1 Natural 5 ☐ Pendin	9	of Injury oth, Day Year)	28b. Time of Injury	м 28	Sc. Injury Work	at ? ′es 2∐1		8d. Describe h	iow injury	occurred	
<u> S</u>	or Attencation death Director: in by the	ficat	2 Accident investig 3 Suicide 6 Could r	ot be	e of Injury - At hor	me farm str			63 2 🗆 1		8f Location (S	itreet and	Number or F	Rural Route Number,
2	after Dire	Certification;	4 Homicide determ	ned build	ting, etc. (Specify)	oot, ractory,	omos			City or Ton		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	iarar riodio reambor,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	aic	29a. Certifier 1 Certifyin	g Physician: To th	e best of my know	wledge, death	occurred a	t the time	e, date and	d place, a	nd due to the	cause(s) a	nd manner a	is stated.
	he Ho in 24 he Fu pletel	edicai	(Check only 2 Medical one)	Examiner: On the	pasis of examinati nner stated.	ion and/or inv	estigation,	in my op	inion, deat	th occurre	d at the time, o	date and p	lace, and du	ie to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4/				License				29d. Date	signed (Mon	nth, Day, Year)
			11/1	1	DO FAR	1	1	429	20	7		law	uny	12 6008
	Q		30 N me and addre s of person	who completed cau	ise of death (Item	23а) (Туре,	Print)		1	111		r	/ ///	571.11.
20	U		1 Exer Lawes 31. Date filed (Month, Day, Year)	7 70 1	AGE 30 Registrar's Signat	or b	usue	48(life	_Wo	y they	eur	M	12 2008
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			1 - For State Registrar	State of Maryla		artment of F		-	giene 008	00979
	Physic		1. Decedent's Name (First, Middle, Las	1 . 3' 11 .	m3			2. Date of Dea Month	Day / 2 Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Dea	th	4c. County of Death	\
ľ	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday) Yrs.	ff Under 1 Year Months Days	ff Under 24 Hrs Hours Min		y, Year) 9. Birth Cou	place (State or Foreign ntry) land
	yland		Usuaf Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation			-	10d. Inside City Limits
	th the Mar	Director	Maryland Harford 10e. Street and Number	Fc	dgewood	10f. Zip Code			10g. Citizen of What Cou	1 ☐ Yes 2 ☐ No ntry?
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f ehow event, ital Madical Examinar must be notified at	Funeral D	1536 Harford Squ 11. Marital Status **TXNever Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No	U.S. 13. \	2104 Was Decedent of H f Yes, specify Cuba		Specify Yes or No- to Rican, etc.)	USA 14. Race - Ameri Black, White,	
Maryland 21215-0036	72 hours a natural', or	by	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace)	If Yes, Give Year or Dates:	16a. Deced	l ☐ Yes 2 → No lent's Usual Occup kind of work done		prkina	Specify: B 16b. Kind of Business/Ir	lack dustry
וצוצו	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last)	Coflege (1-4or 5+)	life. L	NOT use retired Worked	n)			
yland		To Be	Brian Lee Will				Chacon	da Denis	Maiden Sumame) e Harrell	
	d 2 T te		19a. fnformant's Name/Relationship (T Brian Lee William						or, City or Town, State, Zij ${ m d}$, MD 21040	Code)
baitimore,	of to		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	-	sition (Name of natory or other place Service C	1	Date 9-08	20c. Location - City or T Towson Man	
gall	permit. Page Department Important: If any injury o		21. Signatura of Puneral Fervice Licens		22 1V	Name and Address ICCOMAS F	ss of Facility uneral H	ome, P.A	gdon, Maryl	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conse	quence of):	er the mode of dyin	g, such as cardía	c or respiratory ar	řest,	Approximate Interval Between Onset and Death
	hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
o you .	death certific e attending p d for use as	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. ff yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
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vitai neco	n: The law re ficate has be or, page 2 sho	e Completed	25. Was associated to radial					1 ☐ Yes	sy prior to co death? 2 No 1 ☐ Yes	psy findings available mpletion of cause of
VISION OF VI	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	dospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c, Injury Work	er: 4 🗆 Nursing H		ence 6 Other (Special own injury occurred	ýv)
	ital or Atters set al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		et, factory, office		28f. Location (S City or Tow	itreet and Number or Rur n, State)	al Route Number,
	the Hospi in 24 hou the Funer ipletely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my op	oinion, death occu	urred at the time, o	date and place, and due t	o the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	- ~		29c. License	number	2	29d. Date signed (Month, 1//3/20 The Levy, r	Dey, Year)
	1		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Туре, F	Print)	2/014	Chana	47 Levy, r	n.O.
g .	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	K.				

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			1 - For State Registrar			artment of t rtificate of			Jien e V V V) 00700
	Physici /Medic		1. Decedent's Name (First, Middle, Last JERN LYAH	DEL	JAE	WALL	ACE	2. Date of Dea Month JANUAR	Day Ye	
	Examir		4a. Facility Name (If not institution, give				or Location of Deatl	h	4c. County of D	George's
	Funeral Director		Southern Maryland 5. Social Security Number none 6. Se		(In yrs. last birthday, Yrs.	Clinto	011 If Under 24 Hrs. Hours Min. 5 41	8. Date of Birth (Month, Dey Jan 9,	9. Year)	Birthplace (State or Foreign Country) aryland
	D		Usual Residence of Decedent		10- Cir. T					
	farylar show	o.	10a. State 10b. County MD Charles		10c. City, Town or L					10d. Inside City Limits 1 Tes 2 No
	28a-	rect	10e. Street and Number		Bryans	10f. Zip Code		1.	10g. Citizen of Wha	
	th with	al D	2466 Kipp Court			2	20616		USA	1
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examiner must be multified at ODGs.	by Funeral Director	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. black
21215-0036	within 72 ho ane. than natura	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5-	(Give	DO NOT use retire	during most of wor	rking	16b. Kind of Busine	ess/Industry
9	filed Hygie other	a)	17. Father's Name (First, Middle, Last)	ione	nor	16	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u>lan</u>	Mental Mental rked c	ToB	Otha Wallace				Tyr	nise King	Š	
Maryland	alth and I		19a. Informant's Name/Relationship (7) Southern Maryland				and Number or Au s Road Cl		r, City or Town, Star ID 20735	te, Zip Code)
Baltimore,	Pages 1 a nent of Hea ant: If Item ury or othe	5	20a. Method of Disposition 1 Burial 2 Cremation 3 6 4 Donation 5 XOther (Specify)		1	osition (Name of matory or other pla	сө)	Date	20c. Location - City	or Town, State
Balt	permit. Departr importa any inji		21. Signature of Funeral Struce Licens	Water Dire			ess of Facility Comy Boar MD 212		Baltimor	e Street
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	ficate be executed ficate be executed for the physician and first the burial-transit for the first fir	edical Examiner	Sequentially list conditions, any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	consequence of):					
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ds, r	signed by	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	inderlying cause given	ven in Part I.	23e. Did to	~ ^	te to the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autope perfor 1 Yes	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq \) No
/Ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Jamital: . 0		04		ath (Check only or	18)	
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DIVIS	at or Atters after des ster de	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the corred at the time, co	ause(s) and manne late and place, and	or as stated. due to the cause(s)
	To the within 2 To the Complet	W	29b. Signature and title of certifier	llarly Mi		29c. Licens	se number	2	29d. Date signed (M	fonth, Day, Year)
			30. Name and address of person who or)		
	-01		FRNESTO GALLARDO	7503 - 32. Registrar	SURRATTS	FLD. CL	INTON ,	ND 201	D.D.	
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			1 - State Registrar	State of Man		artment of He tificate of D		Re	g. No. 2008	00981
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	n Day Year	3. Time of Death
	/Medic		Norval Claude Wa					January	1	1:20 PM M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or I			4c. County of Death	
E	_		623 Nollmeyer Roa		n yrs. last birthday)	Baltimo	If Under 24 Hrs.	8. Date of Birth	Baltimor	
	Funeral Director		5. Social Security Number 6. S 1 218–36–4554	K7M 2□E	66 Yrs.	Months Days	Hours Min.	May 24,	Year) South	place (State or Foreign ntry)
			Usual Residence of Decedent		30			may 24,	1941 Mary	Tanu
	yland		10a. State 10b. County	10	Dc. City, Town or Lo	cation				10d. Inside City Limits
	Mar	to	MD Baltim	ore	Balti:	more				1 ☐ Yes 2☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	death with the Maryland rms 23a or 28a-f ehow r.must.ke.notified at	al	623 Nollmeyer Ro	ad		21220)		USA	
215-0036	n 72 hours after death with the Marylan "neture!", or Items 23s or 28s-1 ehow adical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of His I Yes, specify Cuban I □ Yes 2【 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
ה ה	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. Deced	ient's Usual Occupat	ion iring most of work	tina	16b. Kind of Business/Ir	ndustry unk
	within 72 ene. then "nel	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)		9		
7		S	12	0	S	tee1worke				
yland	d ta b	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, A		
2	should nd Men marke	2	Harold K. Kanzle					Robertso		p Code) unk
, Mai	od 2 Ith a		19a. Informant's Name/Relationship (Leslie Walter/br	• • • • • • • • • • • • • • • • • • • •	19b. Mailir	ig Address (Street ar	nd Number or Hur	ai Houte Number,	City or Town, State, Zi	p Code) unk
imore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place		Date	20c. Location - City or T	own, State
Dail	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licen	Wade, Nices		Name and Address ate Anato ltimore,			Baltimore S	Street
н			23a. Part Enter the disease, or com- shock or heart lailure. List only	plications that caused the					est,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Selfinfli Due to (or as a c		shot wo	and to	shead		Onset and Death
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s	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
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7	that the part of t	by Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in the un	nderlying cause giver	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
coras	w requires been sign should be		****					1 □ Ye	s 2 No 3 Pro	bably 4 Unknown
Hecc	rsician: The law re s certificete has be director, page 2 sh	Completed						24a. Was ar autops perform 1 Yes 2	y prior to c	opsy findings available ompletion of cause of
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0	ding Phys h. After this funeral di		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of	28c. Injury Work	at ?	28d. Describe ho	w injury occurred Sign	if in flicted
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DIVISION	To the Hospital or Attending Physician: The within 24 hours elited dash, To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification;	Suicide 6 Could not be determined	28e. Place of Injury building, etc. (Specify)			28f. Location (St. City or Town	reet and Number or Rui , State) 623 Vc 1	ral Route Number.
	pital urs e erai C	O	20a Cadiliar III Cadilia - Ph	-1-i T	Hom			Baltima	r W9 512	
	Hosp 24 ho Fund stely f	Medicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exan	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or inv	occurred at the time vestigation, in my opi	e, date and place, nion, death occur	and due to the cared at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and tiple of certifier	and mainlet states		29c. License	number	2	9d. Date signed (Month	. Day. Year)
į	⊢≯⊢ŏ		M Joseph Land Mi	D 1	1	1101	1.7	-	-	14 2 - 5
3			30 Name and address of person who	completed cause of Apat	h (Item 23a) (Type,	Print)	061		January 1	7,2003
			Whitestot I have) 6 Trink	11: H & 1	CT Luth	escrilla	Mdz	5 201	
	Sta	te	31. Date filed (Month, Pay, Year)	ກາດ 32 Registrar's	Signature	- N - W 1 -	- VINCE	1		
	Registr		JAN TO 7	UUO State	o still the	and I				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 11:55A M MARY **LUBABETI** OUNG 16 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor Universit 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 28 1950 **Funeral** Birthplace (State or Foreign Country) Months 1 M 2 X F 57 Director 212-56-5347 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel **Odenton** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Timberbrook Court 21113 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Claims Representative</u> Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Jarvis **Elsie** Simpson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 19a. Informant's Name/Relationship (Type. Print) Fred L. Coover - Attorney 10500 Little Patuxent Pkwy. Ste. 420, Columbia, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/18/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metzstatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 250 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page 2 death? 1 ☐ Yes 2∏ No 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA funeral Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide or / e Funeral Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 esmodel 31. Date filed (Month, Day, 32. Registrar's Signature State good.

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physi	cian	Decedent's Name (First, Middle, Last) JAMES LEWIS ABBOTT	Month Ø 1	Day O Q	Year &8	2249 M
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permit. Pages 1 Department of H Important: If Ite	ouce	21. Signature of Coneral Service Licensee 22. Name and Address of Facility Bradshaw & Sons 306 W. Main St.	Funeral	.Home	- 030	3 C
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	D State	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	1-110131	1	1-1	- /·

Registrar

JAN 0 7 2008

Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month 3, 2008 Richard Y. Beckley January 6:25a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 206 Hollywood Beach Rd. Chesapeake City Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** September 8,1932 1 □ MM 2 □ F Yrs Director 75 222-18-4996 Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1 ☐ Yes 2 No MD Ceci1 Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Hollywood Beach Rd. 21915 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No White Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ath and Mental Hygiene.
27 is marked other than ' than Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly DuPont Company 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Beckley Reva Cole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health al Important: If item 27 is any injury or other trauonce. Betty Beckley/Wife 206 Hollywood Beach Rd., Chesapeake City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Rose of Lima Chesapeake City, MD 2008 21. Sig ature of S 22. Name and Address of Facility rvice Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not effect the mode of dying, short as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. imate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AVdite /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed W05 Cel-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician s the buria Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ThJ.11 cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy certificate 2 No 1□ Yes 2 ZNO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only on. 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month Pay

gistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month The1ma Dee Brittain 2, 5:39 p 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) May 2, 1922 **Funeral** Birthplace (State or Foreign Country) Days Hours 1 M 2 F 418-20-3053 Director 85 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner πust be notified at Director 1 Yes 2 No Montgomery 10g, Citizen of What Country? 'natural", or items 23a 8805 Walnut Hill Road 20815 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennings Nix Rosa Burton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8805 Walnut Hill Road, Chevy Chase, MD 20815 item 27 i Patricia Fitzgerald/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) January Valley View Cemetery 2008 Nokesville, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolism **Physician** vimonary /Medical Due to (or as a consequence of): Examiner avoliomyopathy diopathic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to\(or as a consequence of): Due to (or as a consequence of): Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 █ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No Vital 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 2₩ER/Outpatient 3 DOA Certification: To 1 Inpatient o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year,

JAN

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29c. License number

Strauss, mo 8600 and Georgetown Road, Bethesda Moryland 20814

29d. Date signed (Month, Day, Year)

and manner stated.

32 Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) Type Print)

State Registrar

		1 = For State Registrar	State	of Marylan		artment of F		l Mental Hyg	jiene Jeg. No. 4	2008	00987
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Funer Directo		5. Social Security Number 230–24–2145	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day	Year) 5 192	Cour	elace (State or Foreign htry) Virginia
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eath atten	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fetal and the control of the	death 3	Ectopic pregnancy Other (specify)			230	 Date of deliver Month 	ry Day Year
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requires that the death certifications is a second of the strending should be detached for use as	by Pt	Part II. Other significant condit	ions contributing to d	leath but not resul	lting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use	contribute to the	e cause of death?
quire, n sign	Ω Ω							1 □ Ye	s 2 🗆 N	lo 3 ☐ Proba	ably 4 Unknown
ysician: The law requir ysician: The law requir is certificate has been s director, page 2 should	Completed							24a. Was a	2	4h Were auton	sev findings available
The late had age 2	E							autops perform	ned?	death?	psy findings available apletion of cause of
lan: rtifica	a	25. Was case referred to medic	al				26 Place of De	1 ☐ Yes 2		1 🗆 Yes	2 ☑ No
nysic nysic nis ce direc	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2 E	R/Outpatient	3□ DOA Othe		Home 5 Reside		Other (Specific	1
ding Ph. h. After thi		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date	of Injury th, Day Year)	28b. Time of	28c. Injury Work		28d. Describe ho			/
ttendir death. tor: At	atlc	2 ☐ Accident invest	igation	, oay . oa,,	inquiy		es 2 □ No				
or Att	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 286. Place	of Injury - At honing, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Str City or Town	eet and N	lumber or Rural	Route Number,
urs at	ပ	20.0.4									
To the Hospital or Attending Physician: The law requires that the death certifully a hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	one)		best of my know asis of examination ner stated.	ledge, death on and/or inv	occurred at the time estigation, in my op	e, date and plac inion, death occ	e, and due to the ca urred at the time, da	use(s) and te and pla	d manner as sta ace, and due to	ated. the cause(s)
To	2	29b. Signature and title of certific	196g	MD.	-	29c. License	number	29	d. Date si	igned (Month, E	Dey, Year)
			1/1	111.2		D47	288		1	8,200	>8
6/1 6		30. Name and address of person	who pleted caus	se of death (Item 2	23a) (Type, F	Print)	ercan.	1.72.79			
DH-12		hahren Jah	12801	CAKhii	AV	6 Hage	TUVIT	Will	9	1745	
Si Regis	tate trar	31. Date filed (Month, Day, Year		leg ar's Signatu	ire .	1					
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DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~- "any injury or other traumatic event."

Physician /Medical Examiner

inding physician and use as the burial-tran been signed by the a should be detached within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Hospital or Attending Physician:

1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 January 12:40 P M Ronald James Clarke Sr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1XM 2□F Months Hours Min. 214-34-9903 70 March 31,1937 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick YYes 2 No Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Genesis Lane Funeral 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🙀 No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Vietnam Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard <u>Security</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles **Clarke Ambrosia** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Clarke/Daughter 1340 Almagre Peak Drive, Colorado Sprongs, CO 80921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State ty Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Resthaven Mem. Gards 1/7/2008 Frederick, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home, PA Thurmont, MD 21788 104 E. Main Street complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. rt1. Enter e diseas lock, or eart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No Certification: To 1 ☐ Yes 2X ER/Outpatient 3 □ DOA 5 Te Bacid e— 6 ☐Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) anuary 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Convey 95 Thomas Johnson Drive, Frederick, MD 21702 31. Date filed (Month, Day, Year) Registrar's Signature State MAN 0 7 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 1 Day 2008 Year Physician Marjorie Darlene Chaney 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8137 Crabapple Lane Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) March 3, 1 Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 218-56-5508 1 □ M 2 ₩ F 56 Yrs 1951 Washington Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ns 23a o must b 8137 Crabapple Lane 20879 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🖾 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Klem Nadine Long ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Jesse M. Chaney (Spouse) 8137 Crabapple Lane, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If its any injury or o once. Mecropolitan 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State January 2, Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed: 2 X No To the Hospital or Attending Physician: within 24 hours fler death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place, and place and place and place. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) emore W 0064615 January 2, 2008 30. Nome and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski M.D., 1355 Piccard Drive Suite 100, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year) JAN 04 2008

32 Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of Ma	-	epartment of F Certificate of			eg. No.2 0 0 8	00991
		š.	Decedent's Name (First, Middle,	Last)		<u> </u>		2. Date of Deat	th	3. Time of Death
State of	Physici /Medic		ELI	TAB	CAME	BELL II		JANUARY	Z 1 2008	11:59 P ^M
	Examin		4a. Facility Name (If not institution,	,			r Location of Death		4c. County of Dea	
F-1			PRINCE GEORGI 5. Social Security Number			CHEVE		9 Date of Birth		GEORGE'S
	Funeral Director		262-77-6737 Usual Residence of Decedent	3. Sex 1 ☑ M 2 ☐ F 7. Age 3	(In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, MARCH 2	Year) 9. Bl 21 1968 FL	rthplace (State or Foreign ountry) ORDIA
	land ow at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	a-f sh	ż	MD PRINCI	E GEORGE'S	MITC	CHELLVILLE				1X Yes 2 No
	or 28g	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a c ust b		1810 SPANISH (OAK LANE		20721			USA	
36	be filed within 72 hours after death with the Maryland Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Head of Figure 1 and Yes 2 No1 □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify:	
15-0036	n 72 hou "natura edical E	Completed !	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	eation during most of wor	king	16b. Kind of Business	s/Industry
12	withi iene. r than the M	omp	Elementary/Secondary (0-12)	College (1-4or 5+ 4 YRS	.)	E PRESIDEN	•		ES PRT	VATE
פַ	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, La		1 1 1 0	L TRESIDEN		ne (First, Middle, M		VAIL
/lar		To E	ELI CAMPBELI	SR.			LET	THA JOR	RDAN	
Maryland	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship	1.71		Mailing Address (Street				, ,
_	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	1	ELI CAMPBELL SR. 20a. Method of Disposition	/ FATHER						EORGIA 30248
Baltimore,	0 0		tv⊡ Burial 2 ☐ Cremation 3	B □Removal from State		Disposition (Name of crematory or other place	1		20c. Location - City o	
		1	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		EAST LA	WN CEMETER 22. Name and Addre			CDONOUGH, OKINS FUNE	
B	permit. Departi		Muahno	donuk	1				ER MARYLANI	
ii e	May V		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused t	he death. Do no	t enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition	2	PAD.	818				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	/	1		1/	
2 5 20	LAdimine	<u></u>	Sequentially list conditions,	b Huna	n Important	mundae	+10101	204	Viras	ī
	nsit	Examiner	seque mally list our ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence or,					
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98760	tificate be executed g physician and as the burial-transit	edical		d						
	as a		IF FEMALE:	722						
O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	! ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		23d. Date of de Month	elivery Day Year
<u>.</u>	that til ed by detac	Ph	Part II. Other significant condition	s contributing to death but	not resulting in the	he underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
Hecords,	w requires that the de been signed by the should be detached	ted by				·		1 □ Y∈	es 2∏aÍNo 3⊟F	robably 4 Unknown
		Completed						24a. Was a autops perforr 1∐ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of s 2∑ No
Vital	ding Physician: Th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		etiont 27 DOA Oth	or:	th (Check only on		
ō	Phys rr this aral dii	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		allerit 3 DOA	4 ☐ Nursing H		ence 6 Other (Spa	ecify)
0	nding th. r: Afte e fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year) Inju		k? Yes 2 □ No		mijary occarrod	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm (Specify)	n, street, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
	e Hospitt 24 hours e Funera letely fille	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner state	examination and/	death occurred at the til or investigation, in my o	me, date and place	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. le to the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Mon	th, Day, Year)
}			aniedos	& RM		DO	0661	2 1	-3 - 2	2008
R	(12))	30. Name and address of person wi	no completed cause of dea	300/ H	OSDITAL 1	OR CHE	VERIU .	-3-2 mo 20:	185
	Sta Registr		31. Date filed (Month, Day, Year) IAN 0 3 2008	32. Registrar	's Signature			7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GLENN EDWARD DILLOW 2008 2124 P M 01 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Medical Cente Salisbury MD WICOMICO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Country) | Min. | APRIL 22,1949 | MARYLAND 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2□F 219-50-0314 58 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at SUSSEX 1 XYes 2 □ No DELAWARE LAUREL Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ıral", or items 23a or Exaπlner must be 9832 LOBLOLLY AVENUE 19956 AMERICA death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TX es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be LEROY DILLOW REBSTOCK ANNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN A. DILLOW - WIFE 9832 LOBLOLLY AVE.LAUREL, DELAWARE 19956 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CREMATORY OF Place) 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/08 DELMAR, DELAWARE DELMARVA 21. Signature Service Lice WATTONA TEST FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DE. 19973 Parti Ent use diseas shock, r h art failure aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. Approximate Interval Between Onset and Death complications the Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only N. T. 29c. License number 29b. Signature and title of certifier

State Registrar

900288

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YARADARAJAN

D0063991

100 E. CARROLL ST. SALISBURY MD 21801

			For State	State of Ma	aryland / Dep	artment of l				00993
27	A		Registrar 1. Decedent's Name (First, Middle, La	st)		Timoato or	Death	2. Date of Deat	eg. No:	3. Time of Death
п	Physic		FRANCI	,	GRAY			Month Jan	Day Year 1, 2008	12:15P ^M
190	/Medi Exami		4a. Facility Name (If not institution, giv		CIUII	4b. City, Town,	or Location of Death		4c. County of Death	
	38		18124 Metz Dr:	ive		Germa	antown		Montgon	nerv
- %:	Funeral		Social Security Number 6. S		e (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign untry)
-	Director		216-38-1133	□ M 2 3 F	6.5 Yrs.				21,1942	Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Maryl f sho ied a	ō	MD Montgor	nerv	Ge	ermantow	vn			1 Yes 2 No
	r 28a	irec	10e. Street and Number	2		10f. Zip Code		1	Og. Citizen of What Cou	ıntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minipury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	18124 Metz D:	rive		20	874		U.S.A.	
	deat ms ?	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
9	after or ite	臣	1 X Never Married 2 Married	1 ☐ Yes 2XIN	10	1 ☐ Yes 2 ☐ No		, riioan, otoly		Lack
21215-0036	nours ural"; Il Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	T 40 - D			T		
5	"nat	Completed	15. Decedent's Education (Specify only highest gradual)	ducation ade completed)	16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	ipation e during most of work ed)	king j	16b. Kind of Business/I	•
12	withi iene. than the M	E C	Elementary/Secondary (0-12)	College (1-4or 5			Services		Montgomer Public So	
	Hyg Other ent, t	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nam			2110013
lan	lid be fenta rked ric ev	To B	John N. Sewe	ell Jr			Alvc	e Walla	ice	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	ling Address (Stree	t and Number or Rui	ral Route Number	, City or Town, State, Z	ip Code)
	and 2 ealth a n 27 is		Wilhelmina Gra	ay- Daugh	nter 42	3 Shanno	on Ct Fr	ederick	, MD 2170	
Baltimore,	of He fitten	-	20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or other pla	ace)	Date	20c. Location - City or 1	Fown, State
Ĕ	Pages ment of ant: If its	ł	4 □ Donation 5 □ Other (Special			esley Ce			Clarksbu	
3alt	permit. Departr Importa any inju		21. Signature of Funeral Service Lice		$-D_{I}$				'uneral Ho	
	<u></u> <u> </u>		Diolga	N. Augu	ia		_			, MD20850
			23a. Part1. Enter the diseale, or com shock, or heart failure List only	plications that caused one cause on each lin	the death. Do not e ie.	nter the mode of dy	ring, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	ARY ARTE	RY DISE	ASE			
	Examiner -				a consequence of): L FIBRIL	7 TO TONI				
		ĕ	Sequentially list conditions,	D	i PIBRIII. a consequence of).	JATION				
	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•						
o,	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):					
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ဗ	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitian.	Med	IF FEMALE:							
Box	ath ce ttend or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3	□Ectopic pregnan	су		23d. Date of deli	very Day Year
	at the de by the a tached f	/sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			, and the second	24)
P.0	that the		Part II. Other significant conditions of	contributing to death bu	ut not resulting in the	underlying cause gi	iven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	tw requires that s been signed b should be deta	d by	Hypertensi	วท	Ü	, , ,		1 □ Ye	es 21⊠ No 3⊟ Pro	obably 4 □Unknown
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Re	has ge 2	m E	Hyperlipem	la				autops perforr	y prior to c	topsy findings available ompletion of cause of
<u>a</u>			25. Was case referred to medical				00 81		2. No 1 ☐ Yes	2 ∑ No
or Vital Records,	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatio	ent 3 DOA Ot	thor:	th (Check only on	ence 6 □Other (Spec	nife)
9	g Phy er this eral d	7: To	27. Manner of Death	28a. Date of Inju	ry 28b. Time				ow injury occurred	ny)
Division	Attending Physician: r death. ector: After this certification the funeral director.	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		Yes 2 □ No			
Vis	or Attend after death. Director: / in by the f	iiici	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injubuilding, etc	iry - At home, farm, s	treet, factory, office		28f. Location (St City or Town	reet and Number or Ru State)	ral Route Number,
Ö	ital or A	Ce		J						
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in E	ledical	(Check only 2 Medical Example 12	niner: On the basis of	examination and/or	th occurred at the new investigation, in my	time, date and place, opinion, death occu	, and due to the carred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	one)	and manner sta	ited.	29c Licen	ise number	1.0	Od Data signed (Manth	Doy Vees
	5 ¥ € 8		29b. Signature and title of certifier	1	1 //		054843		9d. Date signed (Month January	
7	25		Jan	1 (2	noth (Itam 00=) (Ti			410		
6			30. Name and address of person who Dr. David A.					410 d Rocky	ville. MD	20850
	Sta	ate	31. Date filed (Month Pay, Year)		ar's Signature					

DHMH 17 Rev 1/2001

1-	For State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 3, 2008 **Physician** Year Gaskins Phillip Vaughn 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barbie's Assisted Living Glendale Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 11, Birthplace (State or Foreign Country) 1**⊠**M 2□ F 578-70-3092 54 Washington, DC Yrs Director Usual Residence of Decedent Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Examiner must be notitled at once. 1 ☐ Yes 2 ₩No Directo Prince George's Maryland 1 4 1 Ft. Washington 10e. Street and Number 10q. Citizen of What Country? 10f. Zip Code 6200 St. Ignatius Drive #103 20744 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No 1974— If Yes, Give Year or Dates: 1978 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black 3 ☐ Widowed → M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Federal Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Thomas Alexander Gaskins 2 Mary Eunice Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomasine Gentry / Sister 6200 St. Ignatius Drive #103 Ft. Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cemetery 01/09/2008 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LIVER FAILURE 6 months /Medical Due to (or as a consequence of): Examiner LIVER TRANSPLANT REJECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of):) L CEV ™ & Ivision of Vital Records, P.O. Box 68760, by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4√JUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b autopsy performed? 2 No 1 Yes 2 X No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Assisted Certification: To 1 ☐ Yes 2XXNo 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier

State

31. Date filed (Month, Day, Year)

30. Name and address of person who compl

Kirti Shetty

29b. Signature and title of certifier

32. Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

2008 03

MD ∜

Registrar

3800 Reservoir Road N.W. Washington, DC

29c. License number

MD03517

20007

29d. Date signed (Month, Day, Year)

			1 - State Registrar		Cer	tificate of I	Death		Reg. No.			
			1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea		Voor	3. Time of Dea	ath
В	Physici /Medic		Jeremiah Hodge,	Sr.				JAN	lay d	2008	1132	M
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death			ity of Death		
			Peninsula legion	nal medical (enter	Sall	Shuru		IN	icom	ico	
F	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Mrs. Hours Min.	8. Date of Birt (Month, Da Apr 23	h v. Year)	9. Birthpl	lace (State or Fo	reign
	Director		200 10 , 000	¹₩™ 2□F 76	Yrs.	monaro Dayo		Apr 23	,1931	Coun	GA .	
	put 🔻		Usual Residence of Decedent 10a. State 10b. County	10c C	ity. Town or Loc	ation				1	0d. Inside City Li	imits
	shores and art	2	MD Wicomi		alisbur						1 □X Yes 2 □	
	the N 28a-f	ect	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	tn/2	
	with a or	Funeral Director				2180	1		rog. Ottzerro	USA	uy:	
	eath	era	105 Times Square	12. Was Decedent Ever in U	J.S. 13. W	1		ecify Yes or No	. 14. Ra	ace - America	an Indian,	
10	fter d r Iten	Fu	1 Never Married 2 Married	Armed Forces? 1 No Ari	TIY		ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	BI	lack, White,		
336	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2Ã No	Specify:		Spec	cify: Blac	CK	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent's E	Education	16a. Decede	ent's Usual Occup	ation	lutus an	16b. Kind of	Business/Inc	dustry	
215	hin 7 e. an "n Medi	ple	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	during most of wor d)	king				
	filed with Hygiene ther thau	5	12			Labore				rious		
pu	al Hy d oth	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Nam			ame)		
yla	should be find Mental had marked of	ု	Walter C. Hodge				Elizabe	th Craf	τ 			
Maryland	2 sho		19a. Informant's Name/Relationship			•	and Number or Ru				*	
	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Ardie Pearson/si				4,2204 Pu					
Ore	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from State	cemetery, crem	ition (Name of atory or other plac	1	Date	20c. Location	1 - City or To	wn, State	
Ë	Pa tmen tant:		4 □ Donation 5 □ Other (Spec		nset Ce		1/8/2		Valdos	sta, G	A	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other toonce.		21. Signature 1 Funeral Service Lice	ensee	Lei	Wis N. Wa	ss of Facility atson Fun	eral Ho	me			
		Н	availer	Mart 1			Rd., Sali)1	Annovimata	
n			23a. Part ¹ . Enter the disease, or cor shock, or heart failure. List onl	nplications that caused the dea y one cause on each line.	th. Do not ente	er the mode of dylin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and Dear	en ith
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	/Medical Examiner		a	Due to (or as a conse	quence of):							
8		<u>-</u>	Sequentially list conditions,	b. ASCV Due to (or as a conse	guence of):							
	ited nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury	CITE	1							
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260	icate be executed physician and s the burial-transit			CRF								
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical										
×	nding use	-2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn					23d. E	Date of delive	ery	
Bo	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	<u>′</u>			Month	Day Yea	ır
P.0	t the	Physician	9 ☐ Unknown	9□Unknown								
	s tha		Part II. Other significant conditions	contributing to death but not re-	sulting in the un-	derlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of deat	:h?
or Vital Records,	quire en sig uld b	Completed by						1 🗆 '	Yes 2 No	3 ☐ Prob	abiy 4 Donk	nown
S	aw re s bee	plet						24a. Was		b. Were auto	psy findings ava	ilable
Æ	The lav	E O						autor perfo	ormed? 2 No	death?	mpletion of caus 2□ No	eor
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2] ER/Outpatient	3 DOA Oth	or	ome 5□Resi		ther (Specif	y)	
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe				
Division	ath. r: Af	atio	1 Natural 5 Pending 2 Accident investigation	on	,,		Yes 2 □ No					
<u>Vis</u>	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		nome, farm, stre	et, factory, office		28f. Location (3	Street and Nur	nber or Rura	al Route Number	r,
	tal ors aft	Certification:										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Spmpletely filled in by the fune	Medical	(Check only 2 Medical Exa	hysician: To the best of my kn aminer: On the basis of examin	owledge, death ation and/or inv	occurred at the tirestigation, in my c	me, date and place opinion, death occu	, and due to the rred at the time.	cause(s) and date and plac	manner as s	tated. the cause(s)	
	the hin 2, the I	Medi	one)	and manner stated.								
	MY		29b. Signature and title of certifier	1.D.		29c. Licens			29d. Date sign	/		
	77/11						7952		51/0	1/08	5	
	n gr		30. Name and address of person who Babulal Dan.		m 23a) (Type, F	onnt) ≠ 504	B. 81	lighen	MA	218	20 4.	
		to	31. Date filed (Month, Day, Year)	32. Registrar's Sign		11 3-1			11:12	-10	, 7	
	Sta Registr		JAN 0 4		H.	Poort .						
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			State of Maryland / Dep 1- State Registrar Amend Item 25 per dr., g876	artment of Health and N PadageOS d be ath	lental Hygi	ene g. No.2 () () 8	00996
П		FΨ	Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici /Medic		Helen A.	Holloway	Month	3 98	1914 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
		de M	Peninsula legional medical Center	Solishury		Wicon	ico
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director	Ì	213-24-2663 1 M 2XIF 79 Yrs.	Months Days Hours Min.	(Month, Day, 18-15-1928	8 Mar	yland
	P .		Usual Residence of Decedent				
	show	L	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e Ma Ba-f s	5	MD Wicomico Salisbu	ıry			1 □Yes 2X No
	ith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	death with the Maryland rms 23a or 28a-f show r must be notified at		27389 Riverside Drive Extended	21801		USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0	or it		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:		Specify: Wh	
2-003p	urai"	d by	3 🕅 Widowed 4 □ Divorced Year or Dates:				
Ö	"nat	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation o kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business	/Industry
V	vithir ane. than	m	Elementary/Secondary (0-12) College (1-4or 5+)				. 1 1
Z	iled v Hygie iher i nt, th		11 Se	ecretary 18 Mother's Nam	e (First, Middle, M	State of M	aryland
aud	l be f ntal H ed of	Be			e (First, Miladie, Mi		
Š	d Me nark	٢	Roger F. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mail				Rayne
2	12 st h and 7 is r traur		, , , , , , , , , , , , , , , , , , , ,	ing Address (Street and Number or Rui	,		,
บ	1 and Healt Sm 2 ther			89 Riverside Drive		l, Salisbu Oc. Location - City or	
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0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrininer must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Box	unds Fune	eral Home	
	PD = 40			05 E. Main Street,			
			23a. Pen 1. Enter the disease, or complications that caused the death. Do not en hock, or heart failure. List only the cause on each line.	iter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Il I'm Cancer			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	ie edy onen dise			
	Examiner	_	Sequentially list conditions, b. aronic onstruct	we fully onen also	se		
56	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events causes.	,			
	ecute and trans	am					
0000	cate be executed physician and the burial-transit	<u> </u>	Due to (or as a consequence of):				
0	bhysic	dical	d				
0	eath certific attending p	Me	IF FEMALE:			- 81	-
2	ath o	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	⊒Ectopic pregnancy		23d. Date of de Month	livery Day Year
	the a	Sic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		WOTH	Day Teal
Ċ	The law requires that the death curtifinate has been signed by the attending page 2 should be detached for use as	Physician/Me		and add the second of the Second	00- 00-		
ń	res th	þ	Part II. Other significant conditions contributing to death but not resulting in the u	andenying cause given in Part I.			the cause of death?
ecolus,	requi	ted			I L Yes	3 2 NO 3 P	robably 4 Tunknown
נ	law as be	ple			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	hysician: The law his certificate has b I director, page 2 s	Completed			perform	ed? death?	2 □ No
12	stan: ertific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one,		
-	Physic this coral dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residen	nce 6 Other (Spe	ecify)
5	tending Ph leath. tor: After th the funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how	v injury occurred	
2	endi eath. or: A he fu	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Š	irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	eet and Number or R State)	ural Route Number,
2	ital or ratio	S					
	Hosp t hou rune ely fil	ca	29a. Certifier (Check only 1	th occurred at the time, date and place,	and due to the cau	use(s) and manner a	s stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director, to the funeral director, to the f	Medical					
	with cor	2	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Moni	h, Day, Year)
	100		Je Ja Vine	1005936		1/3/08	
	00		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	: 1		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frances Hazel Hammett January 2 2008 710 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4955 Sandy Point Road Prince Frederick Calvert 7. Age (In yrs. last birthday, 90 yrs If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Nur 213-42-7974 9. Birthplace (State or Foreign **Funeral** JUNE 621917 1 M 2 XF Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f shov idical Examiner must be notified at Maryland Calvert Prince Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4955 Sandy Point Road 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home hammaker 17. Father's Name (*First, Middle, Last)* Otto Wilhem Reinhardt 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Mae McCully ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Rawlings-daughter 2555 German Chapel Road Prince Frederick, MD 20678 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Astronomy of other place) 1 Burial 2 □ Cremation 3 □ Removal from State Jan 5 2008 Barstow Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Paus h Funeral Home P.A. 21. Signature of Funeral Service Licenses aus 14405 Broomes Island Road Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the 88 use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo. in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension, Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No Physiclan; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weigel, M.D.

John H. Prince Frederick, Maryland 20678 32. Registra Signature 31. Date filed (Month, Day 2008

29c. License number

D26358

29d. Date signed (Month, Day, Year)

Jan. 3, 2008

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281. Location (Street and Number of Hural Houte Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day and Muller M	<u>ק</u>	teath tor:	cat	Z LI Accident	t he	on of initial AAI	hama (a.m. att		Yes 2			3		15 . 1		
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(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day d. M. M. Iley, M. D. 18109 Phice Philipph #375 Olivey, MD 208333 State Registrar 31. Date filed (Month, Day, Year) JAN 0 4 2008		spital ours neral filled		29a. Certifier TC Certifying	Physician: To	the best of my kr	nowledge, deatl	n occurred at the ti	me. date ar	nd place. a	and due to the	cause(s) a	and manner a	s stated		
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	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 0 9 9 9													
	Physici		1. Decedent's Name (First, Middle, Last) Mary Lillian Kellum			-			2. Date of Dea Month January	Dav	2008	3. Time of Death 7:50P M		
	/Medical						own, or Location of Death Plata				4c. County of Death			
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	Director		579-24-0255 1□ M 2 元 F 82 Usual Residence of Decedent	Yrs.	Months	Days	Hours	MIII.	July 28	192	5	place (State or Foreign htty) Maryland		
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	th the A or 28a-	Jirect	MD Charles La Plata 10e. Street and Number 10f. Zip Code							10g. Citize	n of What Cour	ntry?	_	
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900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show eny fujury or other treumetic event, the Medical Examiner must be notified an once.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ANO Specify: 						Black, White, etc. Specify: White			
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) I 1 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Homemaker Home								dustry			
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Mary			19a. Informant's Name/Relationship (Type, Print) Francis Kellum/Husband				nd Number	r or Rural	Route Numbe	er, City or T	Town, State, Zip	Code)		
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	cate be executed /Medical Examiner (the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Operating Death											
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8760,	icate be physicia s the bur	dicai	d										-	
O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) 9 ☐ Unknown							23	23d. Date of delivery Month Day Year			
rds, P.		þ							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
Division of Vital Record		Completed							24a. Was autop perfor	sy	prior to condeath?	psy findings available inpletion of cause of		
Vita		o Be	25. Was case referred to medical examiner? 1 Yes	2 ☐ ER/Outpatien	t 3□ DOA				(Check only o	-	Other (Specific	4		
on of		- 1									5 Desidence 6 Other (Specify) Describe how injury occurred			
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at restigation, in	the time my opir	, date and nion, death	place, ar	nd due to the o	cause(s) ar	nd manner as si lace, and due to	ated. the cause(s)		
}		Σ	29b. Signature and title of certifier 14 Hall		29c. L	icense r	number	5)	- '	29d. Date :	signed (Month,	Day, Year)		
9	BIA		30. Name and address of person who completed cause of death (I			Kri	shan	Math	y M	16	10			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2008 32. Redistrar's Signature	gnature	borle				<u> </u>	,				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Patrick Stephen Kriner /Medical January 2008 5:05P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12571 Substation Road Waldorf Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Director 212-72-4059 47 September 27,1960 Washington DC Usual Residence of Decedent death with the Maryland If item 27 is marked other than "natural", or items 23e or 28e-1 show or other traumatic event. It is Nealsel Examinat must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Charles Director Waldorf 1 ☐ Yes 2√7 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12571 Substation Road 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after u Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatin even. 1 Yes 27 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Kriner Beverly Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Kriner/Son 300 Champions Dr. Apt. 1101, Lufkin, TX 75901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Washington National 1/8/2008 Suitland, Maryland 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Liven ee M01458 St. Mary s mode of dying, such as o Ave. La Plata, MD cardiac or respiratory arrest. 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Ve Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 TYes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 🗌 Yes 2 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. De ribe how injury occurred Certification: After Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) On 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD 170 0 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar 2008